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Hayley Fitzgerald
Barriers to Mental Health
Treatment for Refugees In
Maine: An Exploratory
Study

Abstract

The purpose of this study was to explore the barriers refugees face when it comes to accessing mental health treatment in Maine. Research suggests that refugees underutilize mental health services throughout the United States, despite equal to higher rates of mental health symptoms when compared to the general population. To acquire data, eight refugees were interviewed using a semi-structured interview guide. Participants were asked to share about their perceptions of mental illness and mental health treatment, discuss coping mechanisms that they find useful, and offer suggestions for providers working with refugees. Major findings included that stigma, fear, language, and cultural differences are the largest barriers for refugees when it comes to accessing treatment. Participants expressed that community, humor, and faith are coping mechanisms that are helpful when confronting hardships. Finally, participants felt that providers should reach out to refugee communities to educate refugees about available services and destigmatize mental illness.

BARRIERS TO MENTAL HEALTH TREATMENT FOR REFUGEES IN MAINE:
AN EXPLORATORY STUDY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements for the
degree of Master of Social Work.

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CHAPTER I

Introduction

The process of leaving one's home, whether voluntarily or involuntarily, is comprised of various psychosocial stressors for the individuals and families involved. Migration stressors are viewed as so extensive and disruptive that some have thought of it as another stage being added to the life cycle entirely (Carter & McGoldrick, 1989). Refugees, in particular, face unique stressors and challenges given that they leave their homes involuntarily and often have experienced substantial trauma before leaving. The most common stressors that accompany the process of immigration are: disconnection from family, loss of social support, the potential for unemployment and housing difficulties, pressure to acculturate, discrimination and stigmatization for holding a refugee identity, and uncertainty and fear about the future. Given this, refugees have been shown to be ten times more likely to show symptoms of post-traumatic stress disorder when compared with the general population. Depression and anxiety have also been shown to be more prevalent in relocated groups of refugees compared to non-foreign born populations (Fazel et al., 2005).

More significantly, research shows that immigrants and refugees underutilize mental health services. One study showed that fewer than half of refugees with PTSD will seek treatment (Roberts et al., 2011). Many studies have sought to illuminate the various barriers refugees face when it comes to accessing mental health treatment. These barriers are numerous, and there is not one clear way to alleviate these challenges. It is clear, however, that

improvements need to be made in our approach to addressing these barriers. In the past decade, over 600,000 refugees have resettled to the United States (Office of Refugee Resettlement, 2012), and given the vulnerability of these individuals to higher rates of PTSD and depression, it is imperative that they are given access to effective mental health care.

Portland, Maine is home to the only immigration and refugee resettlement agency in the state. During the 2015 fiscal year, Maine helped resettle 442 refugees in total. The majority were resettled to the cities of Lewiston and Portland. Most of these individuals came from East and Central Africa, as well as Iraq (Catholic Charities, 2016). The purpose of this qualitative study is to explore the following question: what are the barriers refugees in Maine face in accessing mental health treatment? Within this study, refugees will be defined as those who have been forced to flee their country due to fear of persecution “for reasons of race, religion, nationality, membership in a particular social group, or political opinion” (The Refugee Act of 1980). Mental health services will be defined as any service by a licensed clinician intended to address psychological problems for an individual or family.

This study was conducted by interviewing eight refugees in Maine who were all employees of agencies that provide services for other refugees in the state. The participants were recruited using a purposive sampling method. An interview guide was developed to structure the interviews and the questions asked were informed by a literature review that was completed on the topic of access to mental health care for refugees.

Maine, a majority white state, is becoming more racially diverse, and therefore a clearer understanding is needed regarding why refugees underutilize mental health services. One hope for this study is that the data acquired will illuminate the barriers faced by refugees when it

comes to accessing services. Additionally, the data includes important suggestions for possible practice changes mental health providers may find useful when engaging with refugee clients. Finally, I hope that this study will help broaden our understanding of the refugee experience as well as our conceptions of health and well-being.

CHAPTER II

Literature Review

Given the extensive stressors refugees face upon resettlement, it is important to look at literature that clarifies these stressors, identifies barriers for refugees in utilizing mental health treatment, explores ways providers might address these barriers, and localizes this topic to the state of Maine. This qualitative study will explore the barriers to mental health treatment for refugees in Maine. This literature review identifies theoretical and empirical research of stressors faced by refugees, some of the barriers that exist when accessing mental health treatment, and practices that have been useful in addressing these barriers. This chapter will delineate this research and discuss its relevance to the present study. Unequivocally, the existing literature supports the assertion that refugees are not only more vulnerable to developing mental illnesses, but are confronted with various challenges when it comes to accessing services, leading to an underutilization of mental health treatment.

Theoretical Understanding of the Refugee Experience

Acculturation and refugee trauma. In order to better understand the stressors and barriers faced by refugees in utilizing mental health services, it's essential to understand some of the key theories that encompass the process of migration. Acculturation, a term frequently used when discussing the experience of migrants, describes "changes that take place as a result of contact with culturally dissimilar people, groups, and social influences" (Schwartz et al., 2010, p.

237). Acculturation is an aspect of migration where obstacles often arise and it therefore is important to look at more closely in order to better understand the barriers refugees face. “Rethinking the Concept of Acculturation: Implications for Theory and Research” (2010) looks at the concept of acculturation, focusing on its tendency to be used in a reductionist manner when assessing the migrant resettlement process. Schwartz et al. (2010) begin by deconstructing models of acculturation that adopt a ‘one size fits all’ approach, which many argue is inappropriate for a process as complex and personal as acculturation. In challenging the way acculturation is generally conceptualized, Schwartz et al. (2010) put forth a multidimensional model of acculturation which incorporates the contextual factors that influence this process. It is of particular importance, in their view, to include the context of reception in any analysis of acculturation. The context of reception refers to the receiving societies’ attitudes towards migrants, as well as their expectation of how immigrants should acculturate (Schwartz et al., 2010, p. 247). This challenges the frequently held view of acculturation that often treats migrants’ acculturative journeys as defined largely by individual choices without looking at how those choices are constrained by contextual factors. Some of these contextual factors include: fluency in the language of the country of resettlement, type of migrant under consideration (voluntary immigrant, asylum seeker, refugee) and socioeconomic status (Schwartz et al., 2010, p. 240). The model put forth in this article accepts the inherent complexity of acculturation and views it as a process rather than an event. Schwartz et al. (2010) assert that acculturation is multidimensional, especially when assessing the components that are assumed to change over time, namely cultural practices, values, and identifications (p. 244). Many studies in the literature focus on the cultural practice component without giving as much space to cultural values and identifications. This leads to a mischaracterization of the acculturation process because it doesn’t

assess the aspects that aren't as readily visible. This article takes an in-depth look at the way acculturation is often conceptualized and employed and seeks to broaden how it is measured and understood. Any comprehensive study of the refugee experience must adopt a multidimensional view of acculturation to avoid being reductionist in its assessment.

The acculturation process is inevitably influenced by the trauma refugees experience pre- and post-migration. As is often the case with acculturation, conceptualizations of refugee trauma can sometimes be formulated in a one-dimensional way. Miriam George (2010) works to broaden the scope of knowledge about refugee trauma by incorporating Refugee Theory, Postcolonial Theory, Trauma Theory, and Feminist Theory. This allows for the possibility of a more integrated model to assist service providers in identifying trauma factors when working with refugees. Refugee Theory, which doesn't pay much attention to traumatic experiences, helps categorize behavioral patterns of migration, which is useful for providers when working with refugees. Two such categories are 'anticipatory refugee movement' and 'acute refugee movement'. Those in the first group sense danger early, allowing time to prepare for the move. This time for preparation acts as a protective factor for these refugees, unlike those who fall into the acute refugee movement category, who are forced to leave their homes suddenly and often experience and bear witness to traumatic events in the process (George, 2010, p. 380).

Postcolonial Theory helps highlight the ways in which oppressive policies might be influencing a refugee's experience. This theory is rooted in examining the ways in which colonization has historically limited the ability of governments to create economic policy to meet the needs of their citizens. This has often forced individuals to flee to other countries where their basic needs can be met. A refugees' admittance into a country is dependent on the host country government's immigration department, and the potential for abuse in this process is significant. Postcolonial

Theory confronts these power differentials when conceptualizing refugee cases (George, 2010, p. 381). Trauma Theory notes the importance of incorporating social experiences into intervention methods, emphasizing the power and resources individuals already possess to heal themselves from traumatic experiences. For instance, Trauma Theory places value on alternative approaches to healing, such as humor, exercise, and spirituality (George, 2010, p. 382). Finally, Feminist Theory encourages providers to look at the unique, gendered experience refugees have had. For example, female refugees have historically been required to provide medical certificates substantiating their experiences of rape. This would be essential information for providers to have when working with refugees given that these legal experiences could be retraumatizing (George, 2010, p. 384). This article expands our understanding of refugee trauma by incorporating other useful schools of thought. Doing so lends itself to the creation of a more comprehensive case formulation when providing services. While this theoretical background is useful, it does little to explore the actual experiences of refugees, whose voices are absent in this abstract article.

A model of stress and coping. The voices of refugees are essential in any study of this population. Continuing with a theoretical understanding of the refugee experience, Oksana Yakushko (2010) develops a model of stress and coping strategies experienced by immigrants and refugees using grounded theory. To do this, Yakushko worked with leaders of various immigrant communities to obtain qualitative findings. The sample consisted of 20 immigrants from different immigrant communities. The data was gathered through recorded interviews, observational field notes, researcher notes and memos. The findings of this study support the assertion that recent immigrants experience a significant number of stressors before, during, and after the process of migration. Additionally, the stressors are moderated by different contextual factors and conditions. The biopsychosocial model of stress, an ecological theoretical

framework, and the diathesis stress model were all used to understand the research findings and create a useful theoretical lens through which the refugee experience can be better understood (Yakushko, 2010, p. 270). The biopsychosocial model of stress emphasizes the way in which an individual's exposure and response to stress is largely dependent on one's environment. An ecological theoretical framework clarifies that there are multiple contextual factors related to the experience of stress that must be considered when looking at individual function, such as the way the individual interacts with different systems in one's life, from one's family to the healthcare system as a whole. The diathesis stress model suggests that the way in which an individual responds to stress is largely dependent on individual vulnerability, as well as the available coping resources a person possesses (Yakushko, 2010, p. 270). This study is useful in providing various theoretical frameworks within which one can understand the differential impacts of stress on individuals and the mediating role of various resources and coping strategies in this relationship.

Stressors and Barriers Faced by Refugees

Stressors identified. It is undeniable that refugees face numerous stressors before, during, and after their experience of migration. Despite these stressors, refugees have been shown to underutilize mental health services. Saechao et al. (2012) look more deeply at the stressors immigrants and refugees face. This study includes 30 individuals who were placed in focus groups. The participants were grouped by their ethnic identity (6 in total) and each met for 2.5 - 3 hours. Six primary stressors were identified: economic stressors, discrimination, difficulties with acculturation due to language differences, parenting differences, and pressure to find employment. This research is useful in its empirical identification of stressors to treatment faced by refugees. It also utilizes culturally specific methodologies, such as conducting all of the focus groups in the native languages of the participants (Saechao et al., 2010, p. 100). It is

important to note, however, that the six ethnicities reflected in the focus groups (Cambodia, Eastern Europe, Iran, Iraq, Africa, and Vietnam) had cultural norms unique from one another and consequently report different migration experiences. This is on top of the already small sample sizes of each group, making the findings limited in their generalizability.

Barriers to treatment. In the above research, an additional component of the study used the same methodology to identify barriers to accessing mental health treatment for refugees. The primary barriers to accessing treatment were identified as stigma, lack of a norm in the country of origin for using mental health services, competing cultural practices, lack of information, language barriers, and cost of treatment (Saechao et al., 2010). Morris, Popper, Rodwell, Brodine, & Brouwer (2009) investigate barriers to treatment in a comprehensive study which involves interviews with 40 individuals who identify as health care practitioners, employees of refugee services, and refugees themselves. This study was inspired by the dearth of studies on refugee mental health during their year post-resettlement. Most of the existing literature looks at refugee mental health shortly after arrival. The interviews elucidated numerous barriers refugees face when accessing health care, some of which were logistical barriers, such as transportation and insurance issues (Morris et al., 2009, p. 532). Along with these barriers, the most significant challenge reported by the participants were language and communication issues. Many experienced a difficult trade-off where, in order to receive services in one's native language, one had to accept services whose quality was often in question. These language barriers exist at all levels of interaction, including appointment making, filling prescriptions, and dissemination of important medical information. The communication issues were so severe in some instances that it resulted in misdiagnosis and, in one case, the unnecessary involvement of child protective services (Morris et al., 2009, p. 533-534). Difficulty fully acculturating was also identified as a

barrier to utilization of health care among the participants, due to the refugees often holding different cultural beliefs about health and treatment which often conflicted with the current medical model. One such cultural difference is the unfamiliarity of many refugee individuals with the concept and utility of preventative health care. Many reported that they were accustomed to only seeking care when symptoms were severe (Morris et al., 2009, p. 535). The findings of this study are valuable for providers working with refugees because they illuminate barriers to health care treatment and make space for possible directions going forward. One such direction would be to allocate more resources for effective interpreters and quality training to address the issues with language and communication.

Perceptions of Mental Illness Among Refugees

Conceptualization of mental illness. Among much research on the mental health treatment of refugees, an individual's perception of mental illness is often cited as a barrier for seeking treatment. Bettmann, Penney, Greeman, & Lecy (2015) addressed the paucity in the literature regarding Somali refugees' perceptions of mental illness. Somalis constitute one of the largest resettled groups, making this research especially relevant. Bettmann et al. (2015) conducted a qualitative study, interviewing 20 Somali refugees regarding their perceptions of mental illness and its treatment. One of the most consistent findings of the study is that participants frequently describe mental illness in terms of observable, somatic symptoms. (Bettmann et al., 2015, p. 744). This suggests the necessity for medical professionals to become especially able to identify when physical symptoms have psychological origins. This study also clarified the extent to which many Somali individuals believe mental illness is caused by spirit possession or other acts of God (Bettmann et al., 2015, p. 746). This emphasizes the importance of mental health professionals remaining mindful of their biases regarding this belief and the

need for enhancement of their ability to incorporate this into treatment plans and relationship development. This article is very comprehensive in its identification of the perception of mental illness among Somali individuals. Not only does it take an in-depth look at these barriers through empirical study, but it offers possible solutions to the problems. One of the limitations of the article is that, for all of those interviewed, English was their second-language and although they were cited as fluent, there is always the chance that important nuances can get lost in translation.

Understanding how a person conceptualizes mental health is essential to understanding the underutilization of mental health care treatment. Shadi Sahami Martin (2009) looks at this in her study “Illness of the Mind or Illness of the Spirit? Mental Health-Related Conceptualization and Practices of Older Iranian Immigrants.” Using qualitative methods, this study explores the relationship between the way mental health is conceptualized and subsequent mental health practices. Martin (2009) conducted in-depth interviews with 15 Iranian immigrants who had migrated to the United States after the age of 50. Many of the participants held a holistic view of health that did not differentiate between physical and mental health to the extent that many Western providers do. This created difficulties when it came to health care because many had confronted doctors who made separate referrals for each individual issue, which felt like an inappropriate response for the participants. There was a significant mismatch in conceptualization of the problem, ultimately leading to termination of the doctor-patient relationship (Martin 2009). Another way in which differing conceptualizations of mental health played a role was related to the stigma attached to mental health care. Many participants viewed those who sought mental health treatment as “crazy” and believed that they would only be offered psychotropic medication as treatment. Western medicine’s emphasis on targeting problems in the body only addresses part of the problem, in many of the participant’s view, and

neglected the spiritual components of their distress (Martin, 2009, p. 123). This article illuminates issues when it comes to working with older Iranian refugees using the biomedical model of treatment: the conceptualizations of health and illness are fundamentally different, leading to a mismatch in diagnosis and lower overall treatment utilization and efficacy. This is essential to understand for providers who want to work with this population. While the findings of this study are rich, they are limited due to the small sample size used and narrowness of the inclusion criteria. Despite that, it uses qualitative research in a comprehensive way to explore the relationship between mental health conceptualization and mental health practices.

Mental health stigma. As noted above, stigma acts as a significant barrier for refugees when it comes to accessing mental health treatment. In “Beyond Stigma: Barriers to Discussing Mental Health in Refugee Populations”, Shannon, Wieling, Simmelink-McCleary, & Becher (2015) created 13 focus groups composed of Karen, Bhutanese, Somalian, and Ethiopian individuals to investigate stigma and identify further reasons why it is difficult to discuss mental health among these populations. The study looks specifically at why newly arriving individuals find it challenging to talk about the mental health effects of the political violence that caused their migration. The findings of the study fall into seven categories that describe why it’s difficult to discuss mental health: history of political repression, fear, the view that talking is unhelpful, lack of knowledge about mental health, avoidance of symptoms, shame, and culture. Fear was a multidimensional and complex reason, including fear of being seen as crazy, fear of alienation from one’s community, fear of being hospitalized, fear that there are no effective treatments, and fearing the loss of jobs or housing (Shannon et al., 2015). These findings offer useful information for providers when working with refugees. For example, with the knowledge of how often newly arriving refugees experience fear at the thought of seeking out treatment, all

levels of health care teams can work to better emphasize confidentiality with clients, assuring them that their personal information won't be publicized or jeopardize their jobs and housing. The role of education is important for providers and the overall community. Education about what mental health services are offered and psychoeducation aimed at destigmatizing mental health symptoms could act as a force to combat these barriers.

Help-Seeking Behaviors Among Refugees

Alternative treatment methods. Although research shows that refugees underutilize mental health services, many seek and acquire help in alternative ways. Rita Chi-Ying Chung and Keh-Ming Lin (1994) work to gain a better understanding of help-seeking behavior among Southeast Asian refugees by analyzing data that had been originally gathered by the California Southeast Asian Mental Health Needs Assessment Project. This study was conducted in response to the research findings showing that alternative or unconventional health care treatments, such as herbal remedies and acupuncture, are utilized at high rates alongside Western medicine, often without the doctor's knowledge (Chung & Lin, 1994, p. 110). The original data was analyzed for differences in how participants sought health care treatment in their country of origin compared to how they seek health care treatment in the United States. The results of this study indicated that the group of individuals most likely to utilize Western medicine while in the United States were young, had high levels of English proficiency, and had received a formal education. The findings also support previous research in indicating that a significant number of participants still utilize traditional methods of healthcare treatment (39% Hmong, 25% Chinese Vietnamese, 16% Vietnamese, 7% Lao, and 5% Cambodian) (Chung & Lin, 1994, p. 114). These findings are noteworthy in that they indicate the importance of providers inquiring whether individuals use traditional health care methods. This is essential given that traditional methods of treatment can

interact with Western medicine in unpredictable ways and could possibly further jeopardize an individual's health. Another significant finding of the study was how highly correlated education was with the use of Western medicine (Chung & Lin, 1994). The absence of knowledge about what one has as options for treatment presents a significant barrier to those in need of treatment. This study illuminates broad issues within the current healthcare system that make it challenging for refugees to access treatment. Its large sample size ($n = 2,773$) lends itself to be generalizable. While it does mention that utilization doesn't necessarily mean the treatment is effective, it doesn't explore the way Western medicine is privileged in the United States, despite the ways that it may be ill-fitting for many individuals seeking health care treatment. This is a limitation of the study and would be important to look at more carefully in future research.

Obstacles for refugee women. The challenges that refugees face are further complicated for refugee women, who confront unique, gendered obstacles. Using an ecological framework and postcolonial perspective, Donnelly et al. (2011) address the gap in the literature on this topic in their study "If I Was Going to Kill Myself, I Wouldn't Be Calling You. I am Asking for Help: Challenges Influencing Immigrant and Refugee Women's Mental Health". This study is an exploratory qualitative study which features 10 women who identify as refugees, five of whom were born in China, while the other five were born in Sudan. The data revealed that the most influential challenges in seeking help were fear of biomedicine among the women, lack of appropriate services that suit specific needs, and the frequent use among the women of informal support systems and practices to cope with mental health related issues (Donnelly et al., 2011, p. 282). Another notable finding of the study showed that while some of the women sought out mental health care quickly after symptoms emerged, some "waited until their problems grew beyond their control before reaching out for help" (Donnelly, et al., 2011, p. 282). Some of the

reasons for this delay were fear of discrimination and stigmatization, denial of mental illness, fear of unknown consequences, mistrust of Western biomedicine, and multiple roles as a woman and mother in a family system. Lack of awareness of available treatment and anxiety about what treatment may look like served as a barrier to accessing treatment for a significant amount of the women (Donnelly et al., 2011, p. 282). Relatedly, many of the women feared that confidentiality would be an issue and worried that their medical information would be shared with their husbands, who might then use that information to exert more power and control within the relationship (Donnelly et al., 2011, p. 283). These findings are essential for providers to know when working with refugees, especially refugee women, who may benefit from education about available services, including where to go and what to ask for, as well as increased clarification about confidentiality within the clinical relationship.

Successful Approaches to Working with Refugees

Referral process. The stressors that refugees face undeniably make them more vulnerable to developing psychological issues like depression and PTSD. It is also undeniable that clear barriers exist for refugees to properly utilize mental health services. It's important, then, to look at some approaches to working with refugees that have been useful considering these challenges. One study accomplished this by identifying characteristics of successful and unsuccessful mental health referrals of refugees in hopes of clarifying possible policy and practice changes (Shannon, Vinson, Cook, & Lennon, 2015). The researchers in this study analyzed 60 stories of successful referrals and 34 stories of unsuccessful referrals by providers through an online survey. The major characteristics of successful referrals were: active care coordination among providers, establishing trust with the patient, proactive resolution of barriers when they arise, and provision of care that is culturally responsive. The significant

characteristics of unsuccessful referrals were: cultural barriers, lack of care coordination among providers, refusal to see refugees, and system and language barriers (Shannon et al. 2016). One of the strengths of this article is that it empirically identifies characteristics of successful and unsuccessful referrals, giving providers useful information about how better to work with refugee clients on mental health referrals. While this article provides invaluable information about the providers' perspectives, the voices of those whom they serve are absent in this article, a component that would be important to include in further research.

Community contributions. By looking specifically at the experiences of refugee youth and families, Betancourt et al. (2015) explore the effects of using community-based participatory research in two refugee communities for their study. This study sought to better understand the mental health difficulties within the community, community strengths, and help-seeking behaviors of Somali Bantu and Bhutanese refugees. Community-based participatory research is defined as “research that engages researchers and community members in an equitable partnership that typically exists in academic-community relationships” (Betancourt et al. 2015, p. 475). This approach privileges local knowledge and cultural context by including community members in all aspects of the research process. The findings of this study were compiled through free lists and key informant interviews (56 Somali Bantu and 93 Bhutanese individuals). Results indicated that economic and acculturative stressors were especially salient. Participants cited community support as essential in dealing with these hardships, as well as help from health care facilities, government assistance programs, and school personnel. Youth in the community identified areas of psychological difficulty that were similar to Western descriptions of conduct disorder, depression, and anxiety (Betancourt et al., 2015, p. 480). These findings highlight the usefulness of community-based participatory research to better understand the problems faced by

refugee families by allowing participants to be active in the research and describe their experiences in their own language and cultural contexts.

A holistic model. In the existing literature, the study of utilization of mental health services among refugees is situated within a Western conceptualization of mental health treatment that generally involves medication, talk therapy, or a combination of the two. The diagnoses ascribed to individuals within these treatment modalities are frequently used with little to no attention paid to the social, political, and economic factors involved in each individual case. Charles Watters (2001) acknowledges this and builds upon it by investigating the utility of more holistic approaches to treatment that, in part, emphasize the resistance and strength present within refugees (Watters, 2001). This suggested paradigm follows research that indicates that many refugees identify social and economic factors as more important and salient to them than psychological ones. There is little space within the current system for these desires and priorities to be expressed and realized by refugees. Given the structure of our biomedical model, refugees who seek treatment are asked to tell their stories, which are often then translated and sometimes transformed to fit within the existent system, which is generally deficit-based and often leads to stereotyping and essentialism (Watters, 2001, p. 1710). These services leave little room for users to identify what they want from the services and narrate their stories in authentic and fully representative ways. Watters (2001) proposes a three-dimensional model which aims to look at the broader context within which services are located and its inherently reductionist and oppressive frame, focus on the ways in which these services are deployed at local levels, and analyze the direct relationship between providers and clients. He asserts, “In the context of a holistic approach, clinicians will function less as detectives trying to uncover the “real” causes of the presentation of physical symptoms, but will instead be open and receptive to the explanations

given by patients as to the causes of their distress” (Watters, 2001, p. 1713). This, in his view, will lead to a more authentic and empowering model for refugees when it comes to accessing mental health services. It could also provide more space for an emphasis on case management needs, given that many refugees identify this as their primary focus (Watters, 2001, p. 1713).

Refugee Resettlement in Maine

Reasons to resettle in Maine. Maine has seen a large influx of immigrants and refugees, who are often referred to as ‘New Mainers’, over the past 40 years. Many of these individuals find themselves in the city of Lewiston. Ninety-five percent of these refugees are identified as secondary migrants given that they came to Lewiston from a different initial resettlement (Huisman, 2011, p. 2). In “Why Maine? Secondary Migration Decisions of Somali Refugees”, Kimberly Huisman looks at the reasons refugees choose Lewiston, Maine as their home using qualitative analysis. Huisman (2011) uses data acquired from a five-year long project called the Somali Narrative Project, which is composed of twenty-seven individual interviews, eight focus groups, and numerous hours of participant observation. Lewiston is the second largest city in Maine, but it is well-known that it is behind the rest of the state in terms of education and socioeconomic status. This is important to note given that these factors historically act as incentives for individuals to relocate. It is often posited by the general public that refugees settle in Maine for the better welfare benefits. This perception often contributes to discrimination and stigmatization of these individuals and families (Huisman, 2011, p. 14). While the better benefits do act as a motivating factor for individuals, one of the most significant reasons individuals shared that they came to Lewiston was for an improvement in their quality of life, specifically, safety and increased social control, good schools, and affordable housing (Huisman, 2011).

Refugees are often initially resettled to large, inner city neighborhoods which are high in crime, have poor housing, and underfunded schools. Given this, many seek out areas that offer better quality of life, such as Lewiston. Importantly, however, many participants reported viewing Lewiston as a stepping stone in their educational and career journeys, asserting that once a decent education was achieved, the goal was to move out of Maine for work, given the low job opportunities in the state as a whole (Huisman, 2011). Another component of this study looked at the reasons why refugees leave Maine. Although more refugees come to Maine rather than leave it, those who left cited joblessness, racism and lack of religious diversity, and conservative Somali communities in Lewiston (Huisman, 2011, p. 22). This study illuminates some of the key reasons refugees move to Lewiston, Maine from their initial places of resettlement, as well as some of the factors that cause the same individuals to subsequently leave the state.

Socioeconomic considerations. Ryan Allen (2007) endeavors to look more closely at the influence Maine's (with particular attention on Portland, Maine's) social and economic contexts have on the experience of refugees who are resettled there. Maine is one of the most homogeneous states in the U.S. in terms of race and ethnicity. In addition, Maine also happens to be one of the poorest states in New England, largely due to its slow-growing population and the influence of globalization (Allen, 2007, p. 13). Portland is Maine's largest and most economically strong city, and home to a significant portion of the resettled refugees.

Demographically, it is also one of the most diverse cities in the state, although the majority of those in the city identify as white (Allen, 2007). Additionally, the median age of those in the city is younger than anywhere else in the state, making it a vibrant and viable place to live. Allen (2007) asserts that Portland offers much of what newly arriving refugees are looking for: safety, low crime, good public schools, and relatively affordable housing. Conversely, with low job

opportunity, low wages, and little racial diversity, Portland functions as a home for refugees with notable benefits and significant drawbacks. These are important contextual factors to bear in mind when studying the experience of refugees who have been resettled in the state of Maine.

Context of reception. As was addressed above, the context of reception has a significant impact on the overall experience of resettlement for immigrants and refugees. Maine is a majority white state with a high median age and few economic opportunities, which inevitably impacts the way refugees experience resettlement here. Looking more narrowly, the disposition of service providers toward recent immigrants in various cities will have a meaningful impact on the migration process. Comparing Portland, Maine and Olympia, Washington, two cities similar in size which both receive high numbers of immigrants and refugees, Clevenger, Derr, Cadge, & Curran (2014) studied the ways service providers in both locations think about, respond to, and understand recent immigrants. The findings of the study, which are based on interviews of 61 social service providers in Portland and Olympia (some of whom identified as native-born, others as immigrants themselves), indicate that providers in both cities felt a sense of moral responsibility to provide hospitality to strangers and respect every person’s human rights, or the ‘ethic of refuge’ frame, as well as a belief that immigrants and refugees act as important economic and cultural resources, or the ‘community assets’ frame (Clevenger et al., 2014, p. 2). While both cities possessed these frames of thinking, they differed in the common understanding, as well as their articulation, of these frames. Clevenger et al. (2014) posit that these differences are largely due to the historical and social contexts within which each city is situated. For example, within the ‘ethic of refuge’ frame, “providers in Olympia were more likely to emphasize human rights and the importance of extending safety and comfort to immigrants in a climate of fear” (Clevenger et al., 2014, p. 10). This is due to the fact that some

immigrants in Olympia are undocumented and therefore live in fear of deportation, unlike in Portland where individuals are mostly there legally as part of their refugee status. Given this, providers in Portland were more likely to address the uniqueness of each refugee and express compassion and empathy for what refugees in their communities had endured and focus less on issues of safety (Clevenger et al., 2014, p. 11). Regarding the ‘community assets’ frame, providers in Olympia placed priority on providing immigrants tools and skills to utilize within the city, such as navigating transportation and accessing education. In Portland, providers were explicit in their view that refugees influence the workforce and economy in Maine in an essential and valuable way, given that the state’s workforce is older and many young people leave Maine after high school for education and job opportunities. Providers in Portland also emphasized their appreciation for the culture and diversity that immigrants and refugees naturally brought to the city (Clevenger et al., 2014, p. 12). Although both cities described their perceptions of immigrants and refugees in their communities within similar frames, those frames were articulated and understood differently given each city’s unique history and social context. The way in which service providers view recent immigrants influences mental health and access to treatment given that unwelcoming contexts of reception negatively impact the mental health of refugees, and social service providers often act as a source of referral for health care treatment, making this relationship especially important. Given that the proposed study will be situated in Maine, this research is essential to bear in mind as it contributes to the context of reception for refugees in the state and inevitably influences their migration experience and access to mental health services.

Summary

The existing literature indicates that the refugee migration process is multifaceted, complex and, in many ways, unique to each individual who experiences it. Given the uniqueness of this process, not all individuals are left with the same mental health challenges and one's understanding of and access to mental health care treatment is dependent on shifting contextual factors that make the topic all the more challenging to study and understand. The literature on the topic emphasizes that refugees often endure immense pressure to acculturate, carry individual and collective trauma histories, and experience numerous psychosocial stressors, such as difficulty obtaining work and maintaining stable housing. Some of the most significant barriers to accessing mental health treatment identified were language difficulties, lack of knowledge about mental health issues and available treatment, and an overall fear and distrust of the Western biomedical model. Successful approaches to working with refugees were those that provided space for incorporating spirituality into the process of healing, as well as placing emphasis on community support and resources.

The study proposed will take place in the state of Maine. Over the past 40 years, Maine has seen a significant influx of immigrants and refugees, most notably in the cities of Lewiston and Portland. Maine provides good schools, safety, and affordable housing for refugees, but due to its limited availability of jobs, lack of racial diversity and the presence of racism and discrimination within the state, many who are resettled here view it as a step in their journey rather than the destination. While there are studies that explore the barriers refugees face when it comes to accessing mental health treatment, no such study is situated in the state of Maine. This study will fill that gap in the literature and hopefully offer mental health providers in the state of

Maine useful insight and possible directions going forward when working with these new members of our community.

CHAPTER III

Methodology

This qualitative study is designed to explore the following question: *what are the barriers for refugees in Maine in accessing mental health services?* This study is intended to fill the gap in the literature where little is written addressing this area of research. During the 2015 fiscal year, Maine helped resettle 442 refugees in total, and the vast majority were resettled to the cities of Lewiston and Portland (Catholic Charities, 2016). The data elicited from this study will provide mental health workers in the state of Maine with a better understanding of the barriers that exist for refugees when accessing mental health services, as well as useful suggestions for more effective practices in the future.

Qualitative research was chosen for this topic because of its ability to capture rich data, placing emphasis on the voices of the participants. Additionally, qualitative research permits flexibility and inclusivity, allowing for individuals' stories to be uniquely heard and honored. Historically, marginalized populations' experiences have been researched and spoken about in reductive ways. Although qualitative research provides an opportunity for individual voices to be heard, the power differential present in the interviewer-interviewee relationship is essential to

acknowledge and pay attention to. Part of working within this differential requires the interviewer to suspend their assumptions about what is normative in order to be present in attempting to understand the experience of marginalized individuals (Krumer-Nevo, 2002). To further avoid stereotyping, this study used a general inductive approach. An inductive approach helps control the amount of bias entering the study. Rather than conducting this research with a hypothesis in mind, this approach creates space for unanticipated themes and patterns to emerge.

Sample

Participants in this study were individuals who met the following criteria: identify as a refugee, be above the age of eighteen, be fluent in English, be living in Maine, and be willing to discuss their perceptions of, relationship with, and attitudes toward mental health services in Maine. My intention was to have 12 individuals participate in the study in total. My initial plan was to use a purposive sampling method by reaching out to a local agency, Catholic Charities Refugee and Immigration Services, and recruit from among those whom the agency resettles, given that they resettle all the refugees that come through the state. After speaking with someone who works in the agency, she suggested that it might be best to recruit from among the employees of the agency. Her rationale was that, given my inability to offer any compensation, it might be problematic to ask for the time of those who are already so often asked to be interviewed and researched. This led me to reach out to three other agencies in addition, with the same request for permission to recruit from among the employees.

Being an employee at the respective agencies was not part of my inclusion criteria for fear that I might not find 12 participants from these four agencies who identify as employees, and might have to rely on snowball sampling to find the remaining number of participants.

Participants were not required to have been involved in mental health treatment in the past, nor did they need to be currently, in order to participate. The rationale for this is that the study focused primarily on attitudes towards mental health treatment, as well as experiences in trying to access these services. Neither of these components require that the individuals successfully accessed services at any point, although those that had were encouraged to participate.

After obtaining permission from Catholic Charities Refugee and Immigration Services, Healthy Androscoggin, Gateway Community Services, and Maine Access Immigration Network, I was granted approval of my study through the Smith College School for Social Work Human Subjects Review Committee. I then reached out to the agencies and asked those with whom I initially corresponded to send out a recruitment email to all employees, which described the study, inclusion criteria, and nature of participation. I asked that those interested contact me directly to ensure the confidentiality of their participation. During this process, it became quickly apparent that staff members who received this email were not taking the initiative to reach out to me directly. After a few weeks of waiting, I contacted my correspondents at the agencies once again and requested to come into the agencies and discuss my study in person, with the hope that this might interest more participants and help with the recruitment process.

I attended staff meetings at the following three agencies shortly after I made the request: Healthy Androscoggin, Gateway Community Services, and Maine Access Immigration Network. My contact at Catholic Charities Refugee and Immigration Services, while still expressing willingness to help me recruit, shared that given the recent presidential election and impending policy changes, the department was experiencing some internal stress and she requested that I reschedule the meeting. After meeting with the three aforementioned agencies in person, I had five individuals express interest in my study, and arrangements were made for the interviews. I

then attempted to broaden the agencies I hoped to sample from given that I was only halfway to my desired sample size. I sent out emails to agencies I hadn't yet contacted, as well as someone from the University of Southern Maine, with the hope of exploring the possibility of sampling within the school. These attempts were fruitless, and I reached back out to the four agencies to see whether they could lead me in a positive direction. Gateway Community Services invited me to come to their Lewiston campus, since I had only been to their Portland one, and repeat my recruitment speech to the staff there. This helped me acquire two additional participants. Finally, my contact at Catholic Charities contacted me and shared that given recent budget cuts, some of the staff she initially felt would be able to participant were no longer working at the agency. Her efforts did, however, connect me with one participant, a person who had only just stopped working at Catholic Charities after the grant for her position ended. At that point, I felt certain that I had exhausted my efforts to recruit, and settled with a sample size of eight.

Ethics and Safeguards

Confidentiality. Given the inability for this study to be anonymous, all efforts were made to ensure confidentiality for those participating. To do this, those interested in participating contacted me directly so as to avoid other staff or administrative members from knowing who participated in the study. The interviews themselves took place in private rooms where participants weren't able to be overheard or intruded upon. All analysis was completed with names and identifying information being separate from the data, with the link between the two being only known to me. I completed all of the transcription independently, further ensuring confidentiality of the participants' identity. The participant log, audio recorder, and transcripts are now kept in a locked filing cabinet that only I will have access to, where they will continue to be held for three years as required by Federal regulations, after which they will be destroyed or

kept secure as long as they are needed. Before the findings were shared, all information was deidentified to ensure that participants could not be identified from the available data.

Risk and benefits of participation. There was no more than minimal risk associated with participation in my study. However, there was the possibility that some of the interview questions could trigger traumatic memories or be upsetting. Participants were reminded that they could refuse to answer any questions or withdraw from the interview at any time. Through using clinical skills, I was attuned to my participants enough to acknowledge and comment if/when they appeared uncomfortable or distressed. Furthermore, I intended not to have my questions be particularly probing or likely to cause distress. I was confident in my ability to offer empathic listening to the participants and redirect or terminate the interview if this were to occur. I also provided participants with numbers and addresses of supportive services if they were interested in pursuing mental health support, such as community healthcare centers in the area. I was unable to offer material compensation to my participants. However, I intended for my study to function as a place where participants could use their voices and feel heard about a subject that is directly relevant to them. The opportunity to share one's story and feel heard is the most significant benefit to my participants in this study. At the end of the interviews, over half of the participants commented that they felt the study was meaningful and expressed that they were appreciative to have been a part of it.

Data collection. I used a semi-structured interview guide as my qualitative measurement instrument. This was chosen because of the flexibility and inclusivity that is inherent in semistructured interviews. My hope was that the questions asked in the interview guide (see Appendix A) would elicit the necessary information for my study, while still giving participants space to share the nuances of their individual experiences. The interview guide was subject to

review by the Smith College School for Social Work Human Subjects Review and I incorporated feedback that was given to me.

The interviews were intended to take 30 minutes to 1 hour. Six of the interviews lasted approximately 30 minutes, while two of the interviews lasted approximately one hour. The interviews were conducted at mutually agreed upon locations that ensured both privacy and convenience for those participating. Before the interviews, I sent the participants a consent form to look over, as well as my semi-structured interview guide, which contained the questions I would ask. At the time of the interviews, I reviewed the consent form with the participants, and we both signed two copies, one for them to take with them, and one for me to keep with my records. The participants were reminded that they were able to refuse to answer any question or terminate the interview at any point. This did not occur during any of the interviews. The interviews were recorded on an audio recording device. The first four questions asked were demographic questions, which addressed diversity within the group of participants being interviewed. These questions took no more than 5-10 minutes to cover. The remaining questions were open-ended and took up the majority of the interview. This period of the interview lasted from 20 minutes to 40 minutes. The last 5 minutes of the interview focused on wrapping up the conversation and giving the participants the opportunity to share any final thoughts or feelings on the subject. Each participant was given a list of mental health resources in the community, many of which are easily accessible regardless of insurance type.

The audio recordings were downloaded and password protected on my computer. The interviews were then transcribed independently by me. I had considered using a transcription software for this, but found that to ensure accuracy, it was best to complete the transcription personally. The interviews were then stored on my computer separately from one another.

Instead of storing the interview material with the participant's name, I assigned each participant a number and used this as a way to identify them throughout the transcription and analysis process.

Data analysis. I used thematic analysis and content analysis on the data acquired in my study. Thematic analysis “involves the search for and identification of common threads that extend across an entire interview or set of interviews” from which valid inferences can be made (Vaismoradi et al., 2013, p. 400). Given my desire to have a theory emerge inductively from my study, thematic analysis allowed me to identify repeated themes among the interviews rather than looking for predetermined threads or keywords during the analysis. Content analysis, while similar to thematic analysis, focuses on how frequently various themes emerge in the text and creating inferences from these frequencies, making it more objective and systematic (Vaismoradi et al., 2013). Both systems of analysis identify patterns and themes among the data, and thematic analysis' abstract quality pairs well with content analysis' more concrete and quantifiable findings (Vaismoradi et al., 2013).

An important way to ensure credibility and believability of qualitative research findings is to provide readers with a clear picture of how the researcher came to develop the codes and themes that were identified. Providing ample raw data is one way to invite the reader into the process (Drisko, 2013, p. 22). This is a technique I used when presenting the findings of my study.

CHAPTER IV

Findings

This qualitative study seeks to explore the barriers to mental health treatment for refugees in Maine. This chapter will report the findings from eight semi-structured interviews with individuals living in Maine who identify as refugees. One of the major findings of the study was that mental health stigma functions as the strongest barrier when it comes to refugees accessing mental health services. Fear also acts as a significant barrier when it comes to seeking out mental health treatment, most notably the fear of losing one's children and fear of being labelled 'crazy'. Additionally, language barriers, including poor/ineffective translation, were also notably reported as barriers to treatment. Along with clarifying barriers to treatment, the data in this study also revealed coping mechanisms that fall outside traditional Western mental health treatment used by those interviewed, as well as suggestions for providers regarding potential improvements to serving the refugee population in Maine.

The interview consisted of four sections: 1) demographic data about the participants, 2) perceived barriers to mental health treatment for refugees, 3) coping mechanisms that differ from Western mental health treatment, and 4) suggestions for providers regarding how to increase

access to mental health treatment for refugees. This chapter will delineate the findings of those major sections. The questions in the first section were close ended and yielded mostly quantitative data. The breadth of the qualitative information was gathered in the second, third, and fourth sections, with specific themes emerging under each of those headings.

Demographic Data About Participants

Eight individuals were interviewed for this study, all of whom identified as refugees and were members of staff at organizations that serve mainly refugee populations in Central and Southern Maine. Six of the participants identified as female, while two participants identified as male. Ages ranged from 19 to 59 with a mean age of 34. The age at which the participants moved to the United States ranged from 7 to 38, with a mean age of 18. Three of the participants were born in Somalia, while the remaining five participants were born in five distinct countries (South Sudan, Iraq, Ethiopia, Democratic Republic of the Congo, and Kenya). Four of those interviewed had received talk therapy and/or psychiatric services in the past or present. Five of the participants had lived only in the state of Maine while in the U.S., with the other three having lived in at least one other state before settling in Maine. Additionally, all participants apart from one had lived in at least one country other than their birth country and the United States. Seven of those interviewed were active employees at the agencies noted in the Methodology chapter, while one individual had formerly been an employee at one of the agencies and had only recently changed employment due to the grant for her position expiring.

Barriers to Mental Health Treatment

The purpose of this section was for the interviewees to identify perceived barriers to mental health treatment for refugees in Maine. Seven themes emerged as barriers: stigma, fear,

cultural differences, language barriers, practical barriers, lack of education, and spiritual/religious barriers. Each theme will be defined and clarified through the use of raw data.

Stigma. Nearly all participants cited stigma as one of the primary barriers when it comes to refugees accessing mental health services. Many shared that the stigma that exists within different refugee communities is aversive enough that most refugees do not consider mental health treatment as a viable option. One respondent, who grew up in both South Sudan and Uganda, discussed how individuals back home would be shunned from the community if they were identified as having a mental illness: “If you say you are mental, everyone will stay away from you. They will think you are crazy”. She went on to discuss how that mentality still holds true within the refugee community here in Maine: “I don’t have friends because if I disclose what I had and what I’m going through, every day people are going to be like, ‘oh, you’re mental. I don’t want to talk to you’”. Another participant shared that, particularly in her Muslim community, the stigma around mental illness often becomes entangled with one’s relationship with God:

I think it is stigma, like through the community. I think just generally, and I know personally, the Muslim community is stigma to feel like, oh you have a problem and you have to go see a therapist and talk it out, like they’re just kind of like, oh, we can leave it to God and just like you know if you are more faithful or something.

A different respondent, on the topic of mental illness, shared “In my country, to be identified by, as having mental illness issues is kind of shame in my culture”, later adding, “Even if in this country, it’s not a problem to talk about mental issue, but we have, we have, it stick in our mind”. Despite a more open discourse about mental illness in the United States, individuals in her community still hold onto conceptions of mental illness that carry shame and the belief that it

shouldn't be discussed. An interviewee who had lived in the United States from a young age spoke of older generations and the fear of being stigmatized that she witnessed in her community: "They are just scared of what other people will think of them if they seek help... So many people that need the help, but they don't do it because, yeah, oh yeah what would my neighbor think?" The majority of the participants shared that the topic of mental illness carries a stigma so significant that refugees generally won't seek out services and on the rare occasions that they do, they often keep their experiences silent for fear of judgment or rejection. This fear of judgment, in addition to other fears, was identified as a significant barrier with it comes to accessing mental health treatment.

Fear. There were numerous pervasive and salient fears that respondents shared regarding barriers to accessing mental health treatment. Three of the participants explicitly cited fear of losing one's children as a primary barrier for refugee women when it comes to accessing mental health treatment. One woman spoke from her experiences working with refugee families and how she witnessed this particular fear manifest:

So it was, if you went to therapy and you tell them about your history, or what you're struggling with, you be unfit, so CPS, Child Protective Services, would take your kids from you, you would be an unfit mother. Other women would encourage them, "no no don't tell Americans you're crazy" - cause they thought depression equals crazy - so you're gonna be crazy and this doctor is going to tell and you're done raising your kids. Similarly, another woman who also had experienced this fear from many of her clients shared, "They are thinking that I'm that person who's not able to do anything for their family, maybe they will take my kids, they will know that I am scared, I have anxiety, I have something." While these two participants spoke of this fear as they had witnessed it in others, one participant

endorsed the fear firsthand, stating “If you’re claiming that you’re crazy, they are going to take all of your kids. You know, that’s what they do in America.” Fear among refugee women that mental health diagnoses lead to loss of one’s children function as a barrier to accessing treatment from these participants’ perspectives.

Another fear that was noted numerous times was the fear of being labelled, and more specifically, the fear of being labelled ‘crazy’. While this in many ways overlaps with stigma, participants specified that this particular fear was a strong deterrent against accessing mental health services. On the topic of utilizing services, one respondent noted, “They’re not coming, even if they come, and they want to get the service, they just don’t want to be labelled whatever, that’s really the reality.” Other interviewees went on to talk about the conflation in their communities between mental illness and the idea of being crazy: “So when we talk about mental health, they, what comes to the mind of people is like, craziness, someone who’s like crazy, you know, not functioning well.” This misunderstanding of mental illness was felt by another individual, who shared “Our community, like especially the Somali community, like a lot of them believe that counseling and stuff like that is for crazy people.” Many refugees don’t seek out services due to a desire to not be labelled, as well as a fear of being seen as crazy or unable to take care of oneself. She went on to add, “They just are scared of what other people will think of them if they seek help”.

Some other fears that were mentioned less frequently, but are important to note were: fear of speaking to people from a new culture, including mental health clinicians, the fear of losing one’s case management services, and therefore not being completely honest about medication compliance, and the fear of one’s privacy being breached by mental health professionals.

Cultural differences. In addition to the fear of being stigmatized and judged by one's culture of origin, many participants noted that cultural differences as a whole act as a significant barrier to accessing treatment, but also in making a genuine connection with a therapist and sharing one's story. One woman, when discussing a tendency she witnesses in her culture for families to stay inside and want to hide from American culture, shared:

Maybe there is something we are doing, culturally it's correct, but in the other culture, it's incorrect, so it will make trouble for us, so they, but that's not correct because they have to involve more in the community, in most of the activity that's in other community or other culture, so they can learn more how to keep that balance between inside home and outside home.

She witnesses refugee families shelter themselves from interacting with American culture for fear that different cultural practices will be misunderstood and negative consequences will follow.

A younger respondent spoke of her experiences coming to the United States at a young age and the feeling of indebtedness to her family that can sometimes prevent younger refugees from seeking out services: "In my culture you've got to like maintain face, you've got to maintain face basically, save face to your parents because they worked, you know, so hard you know, bringing you to a country of opportunity." She went on to discuss how fortunate she felt because her family was open to the idea of pursuing mental health treatment, and concluded by saying, "So certain families, most of the time it's stigmatization of, just mental health and that's a big stigma and taboo in our culture."

One participant spoke at length about how the mental health system structure is

poorly understood by many refugees given how vastly different it is from many people's country of origins:

The stigma is you know, it's cultural differences. And from the culture we came, there is no established mental health system here. And here, you go through the process, you're diagnosed, and you get help. But over there, physically if somebody calls you crazy, they really see that some of them are not really functioning well, are not functioning well, in terms of they are running around, and you see you know mental really are not capable of doing what other people are doing.

This participant, while sharing that he preferred the more structured system of the United States, had a deep understanding of how misunderstood the mental health care system feels for many refugees and how this results in underutilization of services.

Cultural differences were cited as barriers to initially accessing services, but some respondents discussed how they also inhibit growth and continued care once someone has been established with a therapist or psychiatrist. One woman, who had experienced both talk therapy and psychiatric services, shared, "I think the number one barrier, it's not the language, it's explaining the culture, it's really hard to explain in a therapy session how things were in your culture, and the Somali culture very often overlaps with the religion, so you don't know which one is which." In many ways, so much of the refugees' time in therapy can be spent simply explaining the culture that connection with the therapist and growth becomes inhibited. She expressed this sentiment by continuing to say, "So I think the culture makes it hard, really hard, the person's background makes it really hard for the therapy." Another interviewee felt that cultural differences present a barrier to treatment, but felt as though providers were doing their best to work through that issue, saying, "There is some barriers maybe with understanding the

different culture, but the providers are trying to get more information about these kind of cultures so they can get better.”

Finally, on the topic of cultural differences, two participants spoke about not only the barriers cultural differences present between American culture and one’s culture of origin, but also how these differences manifest intra-culturally and how this acts as a barrier. One woman, who had received services, spoke about the denial she experienced from her community and her family when it came to her experience of depression: “I think one of the things I think I faced the most were, I don’t, people close to you do not believe you when you talk about depression in my culture.” She shared that so many refugees struggle with trauma and mood difficulties that it is seen as immaterial that an individual share this with others and seek out support. Another woman added on to the topic of invalidation of mental illness in her culture, sharing, “Even if you’re depressed, they think of you like, why are you depressed? Like, how are you even depressed if you have faith, you know?” Cultural differences act as a barrier between clients and provider, as well as within one’s culture when it comes to understanding and discussing mental illness. Difficulty explaining cultural differences in therapy were also exacerbated by language barriers and challenges with interpreters.

Language barriers. Language differences were cited as a barrier by nearly all those interviewed. One such way that language acted as a barrier related to the meaning that was lost in the process of interpretation. Three participants noted this particular barrier. When talking about how the cultural differences make therapy difficult, one respondent continued:

Even harder when you use an interpreter - a person that’s interpreting, there’s a loss in translation, in therapy, when you’re trying to speak English and trying to explain how, it’s really hard to make meaningful conversation because there is no verbatim word and

the closest concept doesn't make any sense, because you're talking about another culture so it doesn't make common sense.

She expressed a difficulty in finding words she could use to fully describe how she was feeling to her therapist, "Even for me, when I was in therapy, a lot of times you feel like, 'How will I explain this in English?' and you start looking for the closest concept you can explain, but I don't think it makes the exact meaning that I want it to, that I want to come out, you know?" Another individual who had gone to therapy and had a poor experience doing so, spoke about her therapist's lack of understanding due to language barriers, "He doesn't understand what is going on with me because basically they have to interpret what I'm saying, it's not exactly what I'm saying from my head, but always the meaning lost itself in between the communication." A third participant reinforced these two experiences by sharing, "People in my community have a huge problem of language, so sometimes it is very difficult to explain even if there is an interpreter, you cannot explain exactly what you are facing, what are your symptoms of your problem." It was common among all three participants that whether through an interpreter or one's own translation, many important and meaningful concepts were difficult or impossible to fully describe, diluting the efficacy of therapy and potential for connection with the therapist.

Continuing with the topic of interpreters, one respondent felt strongly that some interpreters do the work for less than pure motivations: "The interpreters are like, some of them, they just do it for like the sake of it, they don't really, especially if you don't have a medical background, you shouldn't even translate it for anyone." She felt this was potentially dangerous, and had witnessed an instance where poor interpretation had detrimental consequences when reflecting a family member's experience, "She had a translator, some of those translators were not really translating the way they were supposed to. So like, they gave her the wrong meds and

she got worse and they took her home, like back in Africa.” Whether it’s meaning that’s lost or more essential medical information that isn’t translated properly, the majority of the individuals interviewed reported language as a primary barrier when it comes to accessing and maintaining mental health services.

Practical barriers. Various practical factors were mentioned as barriers to accessing treatment, among them were: not having insurance, the view among many that therapy is simply a means to obtain different services (social security income, green cards, etc.), lack of transportation, and an overall stronger emphasis among refugees on needing case management services. One participant shared, “Sometimes they say like, let me wait, let me do the case management for a little bit until I’m settled down, then I can do the counseling.” He went on to speak about the bind many refugees face because in order to receive case management services, many need to carry some sort of mental health diagnosis:

I was just talking to these ladies the other day, and someone, you know, thought like, you know, having a case manager, you know, being eligible for case management, was sort of like, you’re not able to work, you’re not independent. And they’re like, oh, they will put me in like bad credit, I will be like a crazy person who is not, who cannot even care for her children, stuff like that.

While this overlaps with the stigma that mental health diagnoses carry, this interviewee spoke about his experience with refugees placing case management needs as the most primary concern, while also having to overcome their beliefs about how a person may be judged or what consequences might arise from carrying a mental health diagnosis and using case management services. These beliefs and misunderstandings about mental health diagnosis and treatment result largely from a lack of education about available services and mental illness in general.

Lack of education. Misinformation and lack of education were barriers mentioned by many of the respondents within different contexts. One woman spoke about her own understanding of the etiology of mental illness and how it was shaped by her experience as a nurse in the Democratic Republic of the Congo:

But as many people don't have enough education, especially medical education, they cannot understand that mental illness is exactly like a cold or any kind of disease. And some of them can be treated, some of them cannot, but it can be managed with medication, but you need to have some education to understand it.

She felt that refugees' lack of education around the causes of mental illnesses prevented them from seeking treatment, as it isn't often viewed as a disease that needs treatment like any other. An interviewee who works as a case manager spoke not about a misunderstanding of mental health or mental health services, but an overall absence of knowledge that the services even exist: "It takes them a while to understand the services we offer. Initially, a lot of people don't know about these programs. Community members, they don't get the services, they don't know." He spoke about the difficulty in engaging refugees in services that they weren't aware were available to them. The lack of education about the services available to refugees, coupled with a broader misunderstanding of mental health, act as significant barriers when it comes to refugees accessing mental health treatment.

Spiritual/religious barriers. The final group of barriers mentioned by the refugees interviewed had to do with spirituality and religion. One woman spoke directly of the Muslim religion acting as a barrier to seeking treatment, particularly in relation to its emphasis on being grateful for one's health and well-being and the lack of space to linger on one's mental health struggles:

I think another barrier is the religion itself... You shouldn't somewhat dwell on the fact, but keep it moving. And every time you keep it moving, to be grateful. It's also like, when you're sick and when you're healthy, you should be equally grateful - so it's kind of hard when you're down on your luck to also show gratitude all the time (laughs). So I think a lot of people feel, like ungrateful is the word, to seek therapy, because here you go, you survived, but other people didn't make it, so what's your problem?

In her view, externalizing and seeking help for one's mental illness may be viewed by many people of the Muslim faith as ungrateful for one's life and survival.

Only one participant personally endorsed a spiritual understanding of the etiology of mental illness and felt that this view was incompatible with Western mental health care. She also had experiences of being silenced when trying to share this with others: "Because when you tell, a lot of people end up in mental institution here in Maine. I'm just like telling them, that's not mental, that's spirit. Spirit catch that person, it's spirit living inside that person. I say that's spirit - they don't believe that." She went on to say that a form of therapy or healing that allows for and emphasizes spiritual beliefs may likely make more sense to some refugees and encourage them to seek out treatment, sharing, "It would be good to have like spiritual healing or therapy because a lot of people believe with that, even though, with the Muslim religion, they believe in the spiritual religion, you know in the spiritual healing and all that kind of stuff." Both of these accounts describe religion and spirituality as barriers to accessing Western mental health services.

Non-traditional Coping Mechanisms

Along with identifying barriers to mental health treatment for refugees, this study yielded results identifying coping mechanisms that may be considered 'non-traditional', with traditional,

for the sake of this study, defined as typical Western mental health treatment (i.e. talk therapy, psychiatric treatment). Four of the participants had never participated in mental health treatment, but believed in its efficacy, two participants had in the past but stopped, (one because she felt like she had met her treatment goals and the other because her experience was so poor), and the remaining two participants were involved in mental health treatment at the time of the interview. That said, each interviewee had ways of coping with life's daily stressors that didn't involve talk therapy and psychiatric medication, and those will be reported in this section.

Community. Connecting with community was cited as a useful coping mechanism among the majority of respondents. Coming together with friends, drinking, and laughing were mentioned by one participant as primary when it comes to healing: "I go over her house, we talk, we laugh, we talk about my old friend, and all that kind of stuff, so it's like, you know, a part of a process of healing in my culture." She went on to emphasize the role of laughing and humor in her community, sharing "They love to party, they love to come together and just laugh and drink like I said. They love to laugh a lot. Laughing, laughing is the only thing - and joke about their problems. That's the only way they heal each other." She spoke about how sometimes this is difficult for Americans to understand, because it can come across as treating difficult topics with too much levity.

A different participant spoke about her workplace and the groups for refugee women that are often held there, whether it's sewing, yoga, or drinking tea. She shared about her experience joining such a group:

They just invite me, come in with us to drink tea together. Just talk, talk with each other, get advice with each other. This life is really difficult here, we have some troubles with our kids, how to manage their time, how to deal with school. So just to sit you know as a

resource as a people from the same community, helping each other to find resources, to help each other, or listen to each other is helpful a lot.

For her, the resources and emotional support shared at these meetings were helpful, especially given all of the unique challenges refugees face when moving to the United States.

A woman who struggles with mental illness, but feels unable to share it with members of her community because of stigma and judgment was able to find community online. She discovered a forum specific to her experience and found it healing to watch videos and read blogs by others with similar stories: “You know I can just watch it, say, ‘oh, I’m not alone. I’m not crazy. I’m not mental, this is actually real.’” Respondents reported that community, whether it’s going to friend’s houses, participating in support or activity groups, or finding a community online can be validating and supportive in immeasurably useful ways.

Religion/spirituality. For about half of the refugees interviewed, religion, and one’s relationship with God, functioned as a strong source of support and solace during challenging times. For some, prayer and going to church was a way in which people were able to stay connected to God. Memorizing the Quran, for one participant, acted as a primary way to maintain that connection: “And meditation, just praying. Just constantly we are just asking us to memorize Quran”. He also felt that prayer was an essential component to this: “First of all, anyone who has faith, praying is one thing, you know, it really gives you less stress in terms of - you can reflect.” Another interviewee enjoyed listening to her church music along with prayer: “Listen to church music a lot and pray kind of thing.” However, prayer and church-going weren’t ubiquitous ways to connect with God, and one woman spoke about her feeling of connection with God through nature, “Well my way of finding God is through nature. I like trees and water”, as well by giving to others, which will be elaborated on more fully in the next section.

Giving to others/humility. For the earlier mentioned participant who found God through nature, donating and giving to others functioned as a way to both connect with God and allow her to feel fulfilled:

I like donations, and helping people who are less fortunate than me. So I have a thing when I get paid, I don't pass anybody on the street, I don't pass any stores that are doing donations.. I have to do a dollar or 50 cents or a quarter, it does not matter. So, donating, giving back, and helping others can be a coping mechanism for me.

She went on to clarify that it's not always about giving material things to those less fortunate, and she shared an important lesson that her mother taught her when she was young, "My mom used to say.. She would say, if you don't have anything to give them, kind words are charity, too." Giving kind words, a quarter, or even just some time was important to this woman, and acted as a coping mechanism for her mental health and well-being.

One interviewee, who was especially contemplative about his appreciation for having survived through many difficult times, reflected upon all those whom he had lost and felt that giving to others was a reward in and of itself. He had committed part of his life to always giving to others, sharing, "Just helping people itself is a kind of reward - something you get internally, you know?" For some of the participants, giving to others and acting selflessly was essential to one's well-being and sense of contentment.

Remaining humble about one's health and carrying a feeling of gratefulness and appreciation for life were also noted as useful coping mechanisms for two participants. One woman, who saw this disposition as essential to part of her religion, spoke about a feeling of obligation to stay humble and appreciate one's good health always: "So for me, in order for me to be a good Muslim person, it's literally I have to serve others, I have to humble myself for the

fact that I'm healthy. You know, because healthy is very priceless." A man seconded this attitude by reflecting on his past and all those who weren't as fortunate as him:

And always, I appreciate life. I just, one of the things, surviving itself is a big thing, you know, a completion just to survive. Being healthy, you know.. You know, so many people don't have a chance to, you know, I look back at my age where I lost a lot of friends, and I just say, you know, thanks to God.

While many may take good health and survival for granted, reflecting on these things functioned as useful means of coping for some of the participants.

Activities/hobbies. For nearly half of the respondents, music functioned as a useful coping mechanism, and one that was relied on heavily in times of stress. As earlier mentioned, church music functioned as a support for one participant. Another individual, however, had one particular type of music that worked as a coping mechanism:

Interviewee: After all, I have my music.

Interviewer: What sort of music?

Interviewee: Only Michael Jackson. Only.

A third participant spoke about her witnessing others use music as a coping mechanism during stressful times, "Some of listening to music, yeah, maybe the music that reminds them of their back home". Music related to one's religion, one's country of origin, or simply music that one enjoyed listening to were all cited as useful means of coping during difficult times. Staying busy, exercise, and Reiki therapy were also noted as activities/hobbies that were helpful.

Suggestions for Providers

After discussing the barriers to mental health treatment for refugees, as well as sharing coping mechanisms that differ from traditional Western mental health treatment, participants in

this study made suggestions for providers that they felt would be helpful in making mental health treatment more accessible. These suggestions fall under the following five categories, which will be elaborated on in this section: outreach, stronger cultural awareness, providing education, feedback/follow-up, and building trust.

Outreach. Some of those interviewed shared that they felt there needed to be better outreach to the refugee community. One woman, who had past experience doing outreach work herself, spoke about the absence of outreach and how useful that may be for those who need the services: “There’s a lot of need, but they’re not reaching out to the community, they should do like I used to do outreach to the community, do a workshop to the community, do a support group for the young people.” Another woman reinforced this suggestion by sharing,

I think like, having events and talking about it, people might come and then just listen to it and you know, change their minds, probably get help, but I don’t know. Or going around and just knocking on people’s houses and telling them about it. Or even just sending a flyer through the mail, I don’t know, something like that.

Whether it’s sending around flyers, holding support groups, or physically going from house to house to explain the services available, some of the participants in this study felt that there wasn’t sufficient outreach taking place, and that improvement in this may increase access to and utilization of mental health services among refugees. One respondent summed this up nicely by stating, “I think that’s best for people, always to reach out to the community, to explain to them how these kind of things work.”

Stronger cultural awareness. Providers strengthening their cultural awareness was also mentioned as potentially useful for making mental health services more accessible for refugees. One woman spoke about how important it is for providers to do research about their client’s

background, which can elicit helpful information, such as how to greet one another: “It’s always good to do research about anybody’s background, where they come from, the country or whatever, the belief system, it’s good to know, you know. Or the way they greet each other, you know, so that’s actually, it’s helpful.”

Another participant, who works as a case manager with refugees, shared some of the stories he’s heard from his clients when they were offended by many of the personal questions they were asked during their intake assessments:

Some people will feel insulted for some questions.. And you know, those tough questions they will ask like, do you smoke, do you have - and some cultures, it’s very offended if you ask someone like, do you drink alcohol, because they see alcohol, someone who drink alcohol is like this (holds hand down) very, very down. One suggestion he made that felt may counteract this would be for providers to be clear and upfront about the fact that the questions aren’t catered to any individual, but are asked of everybody who undergoes the assessment:

“That’s why like someone who understands cultures will be like, excuse me, those are general questions I’m going to ask, I ask everybody.” He went on to discuss the importance of how mental health professions word particular questions. For example, he felt that when refugees are asked questions like, ‘How is your anxiety?’ they may become offended and defensive, without realizing that it’s not intended as an insult or a judgment on someone’s functioning. He made the following suggestion regarding how the questions could alternatively be asked:

If a therapist makes it very easy for them, them, they’ll be like, oh, because of without housing, I don’t sleep well, then the therapist will get all those informations. But if they just ask like, how’s your anxiety, you know, do you sleep well, or do you have panic

attacks, all those, you know, questions, they'll be like, wait a minute, what are you asking me?

Framing the questions in terms of how one's case management needs, such as housing and employment, affects one's mood would be, in the view of this participant, a less confrontational or judgmental way to approach the subject of mental health needs.

Providing education. Lack of education about mental health services was cited by many participants as a barrier to accessing treatment, and providing education about mental health and mental health services was suggested by some of the refugees as a potentially useful practice. One woman, who was currently utilizing mental health services and had a positive experience overall, felt that some improvement needed to be made on the part of primary care physicians: "The mental health therapists are very good, the problem is through the PCP. They need to make refugees understand that it's acceptable and they can be treated, and they can overcome those issues. So the refugee will feel more comfortable and empowered to open up to the psychiatrist." She felt that if the primary care physician was more normalizing and destigmatizing about mental health treatment during the referral process, refugees may feel more comfortable and able to open up once they meet with a psychiatrist or therapist.

Another interviewee, whose job required her to educate refugees about the services available to them and their overall rights, felt that a nation-wide conversation destigmatizing mental health was needed: "I think in general, there needs to be a conversation in the whole United States as a society, like having mental illness doesn't mean you're incapable or unstable." She went on to express the need she felt for more advocacy, specifically for refugees: "I do work closely with refugees and there's cases that we've seen when clients have, just cannot absorb what's going on and sometimes feel threatened and sometimes feel like they're not able to get

those resources available, and I just think there needs to be more advocacy.” She witnessed firsthand how many refugees’ trauma histories impaired their ability at times to absorb information about their rights or services available to them, and she felt that more advocacy would help alleviate some of this disconnect.

Feedback/follow-up. Two participants felt that more feedback and follow-up with refugee clients were needed. One woman had a particular reason why she felt this was necessary, and it was due to medication compliance on the part of refugees. Through her work and in her community, she was aware that some people weren’t taking their medication as prescribed by their psychiatrists, and shared about one reason why this was taking place: “I know those medication, they are very hard on them when they are taking those medications, they told me ‘We can’t manage our normal life at home, we have to be sleeping all the time’, they are very strong medications.” This puts many refugees in a bind, she felt, because they didn’t want to share this with their doctors for fear of seeming as though they don’t really want the help: “If you are not following the instructions, then that mean, okay, you don’t need any kind of help, so who can help you? This is the step one of treatment, I have to give you medication, you have to take them, and then when you are refusing, how can I help you?” She had a suggestion for providers of how to possibly pacify this issue: “They have to look at the result of their treatment and to be careful about what they are giving them.” and “They have to do some tests, is this person taking his medication or not?” For this participant, follow-up on the part of the prescribing doctor was necessary, particular in relation to medication compliance, because, in some cases, effective treatment is not taking place due to some refugees withholding information for fear of losing services.

For another respondent who was working on developing feedback surveys at his job, he felt that more participation by refugees in feedback surveys would be really useful for mental health professionals: “Some people really don’t want to answer the survey, which is really is helping the provider, you know, just evaluate us, how are we doing?” More feedback surveys, and importantly, more participation in the surveys by refugees would be helpful for the providers when evaluating their services and practices.

Building trust. Two respondents spoke about the need on the part of the mental health professionals to focus on building trust with the client before asking personal questions. One woman, who had gone to therapy herself and had a bad experience doing so, shared what it was like for her: “All he just asked me was about my childhood, what happened when I was young, but it really didn’t help and I feel like he actually hurt me more because I talk about all my feelings, my childhood, to a stranger and then at the end I get nothing out of it.” She continued by making a suggestion that may help with this issue of lack of trust, sharing, “They shouldn’t do that yet at the beginning, they should just meet with the client first, second time they start asking those kind of questions, you see.” She felt that asking personal questions early on in the therapeutic relationship drives away refugees and that waiting until trust is developed to ask those questions may help.

Another participant spoke to this by sharing the stories he’s heard from refugees who have gone to treatment, and how damaging it was to the therapeutic process to ask personal questions at the beginning. He shared, “Not first session - they don’t give out a lot of information, then when they come back next time, there will be, you know, a little bit of trust.” These participants felt that pacing the rate of personal questions and being mindful of the negative consequences

that can arise when focus isn't placed on first building trust are important for providers at all levels to keep in mind.

Summary

The major findings from the eight interviews with individuals who identify as refugees living in Maine were presented in the chapter. The most significant findings were that stigma, fear, and language differences are the primary barriers for refugees when it comes to accessing mental health services. Alternative coping methods, as well as suggestions for providers were also shared in this chapter. The following chapter will compare and contrast the results, as well as explore possible interpretations of these findings. Strengths, limitations, and suggestions for future research will also be presented.

CHAPTER V

Discussion

The purpose of this qualitative study was to explore the barriers to mental health treatment for refugees in Maine. In addition to sharing their perspectives on the barriers to mental health treatment, participants discussed individual coping strategies that fell outside traditional Western mental health treatment, and shared some suggestions for providers that may help make mental health care more accessible. This chapter will discuss the study in the following sections: 1) key findings and their relationship to the literature (including a case study of one of the participants), 2) strengths and limitations of the study, 3) implications of this study for social work practice and policy, and 4) recommendations for future research.

Key Findings and Their Relationship to the Literature

The most significant results of this study were that stigma, fear, cultural differences, and language differences act as primary barriers to accessing treatment for refugees. Alternative ways of coping with mental health issues were also elucidated in the process of data collection. Finally, participants shared their suggestions for providers of possible ways to improve access to mental health treatment for refugees. This section will compare the key findings of this study to the previous literature and discuss the coping strategies and suggestions for providers in the

following subsections: stigma, fear, cultural differences, language barriers, alternative ways of coping, and suggestions for providers. Finally, a case study of one of the participants will be shared.

Stigma. The results of this study indicated that the stigma associated with mental health treatment and mental illness in the participants' communities is significant enough to deter refugees from seeking out mental health services. On the occasions when refugees do seek out services, the participants shared that most will not openly speak about it for fear of judgment. This finding is consistent with Martin's (2009) research which explored refugees' conceptions of mental illness and found that there was notable stigma attached to mental health care. In her study, many of the participants felt that only those who were 'crazy' would seek out services, and even then, they believed only psychotropic medication would be offered (p. 123).

Saechao et al. (2010) also reported that the participants in her study viewed stigma as a reason why refugees don't seek out mental health services. In her research, as is similar to the findings of the present study, the cultural unacceptability of mental health treatment acts as a primary barrier when it comes to seeking out services (p. 103). One participant reflected this sentiment in the present study by sharing "They are just scared of what other people will think of them if they seek help... So many people that need the help, but they don't do it because, yeah, oh yeah what would my neighbor think?" Even when the need for mental health treatment is evident, the stigma associated with the topic can prevent refugees from seeking out services.

Fear. Fear was cited by many participants in this study as a barrier impeding access to treatment for refugees. As is the case in much of the literature, fear was a multifaceted barrier in this study, which included the fear of losing one's children, and fear of being called crazy. Notably, the previous research didn't emphasize the fear of losing one's children as a primary

concern for women, as was the view of many participants in this study. However, the work of Donnelly et al. (2011) does purport that refugee women have uniquely gendered obstacles, such as navigating multiple roles one has as a woman and the fear that confidentiality may be breached and personal information may be used against them by their husbands (p. 283). Both the results of this study and the previous literature support the finding that women face unique obstacles due to their gender when it comes to accessing and utilizing mental health services.

In Shannon et al.'s (2015) research exploring barriers to mental health treatment for refugees, the research indicates that the fear of being seen as crazy was a pervasive barrier to accessing treatment. Given the association between mental health treatment and being crazy, Shannon et al. (2015) found that many of the Somali participants in her study would become defensive when asked questions about mental illness (p. 287). This is similar to an experience an individual in the present study shared, who had heard many stories of refugees misunderstanding the meaning of the questions asked of them and often taking offense to these questions: "If they just ask like, how's your anxiety, you know, do you sleep well, or do you have panic attacks, all those, you know, questions, they'll be like, wait a minute, what are you asking me?" The defensiveness some refugees may feel results from an association between the topic of mental health and being seen as crazy, which often impedes utilization of services.

Cultural differences. Cultural differences were mentioned as barriers to mental health treatment among many of the participants with a specificity not cited in much of the previous literature. The participants in this study shared about particular ways in which culture impeded access to mental health services and acts as a deterrent to continuing services on the occasions when they were accessed. Some of these cultural differences were: a feeling of indebtedness among younger refugees to be grateful for the opportunities they were given and therefore not

ask for help, the difficulty that comes with explaining one's culture to providers in the midst of therapy sessions, and relatedly, worry among many refugees that their different cultural practices would be misunderstood and get them in legal trouble, such as the use of physical discipline with children. Perhaps these barriers speak to the context of reception as defined by Schwartz et al. (2010), which emphasizes the ways in which a refugee's ability to acculturate is largely constrained by contextual factors and the expectations and biases held by the receiving society (p. 247). Particularly regarding the fear that cultural practices from one's country of origin may be misunderstood and lead to negative consequences, this speaks more to the context within which refugees find themselves rather than individual deficits or choices. The message that is sent to refugees, however, is that their cultural differences are the problem and this instills fear and apprehension to engage among refugees. The multidimensional model that is put forth in Schwartz et al.'s (2010) research allows space for a complex understanding of acculturation, including a more accepting reframe of cultural practices that differ from one's own. The barriers that exist regarding cultural differences were noted in the previous literature and more specifically delineated in the findings of the present study.

Language barriers. Language differences were mentioned as primary barriers to services in this study, and this reflects much of the previous research. Most participants in this study shared about the meaning and sometimes the content that is lost when an interpreter is needed to converse with providers on behalf of refugees. This ranged from innocuous mistranslations to an inability to fully convey one's story and symptoms, making it impossible for a connection with the provider and effective treatment to take place. This finding is reflected in Morris et al.'s (2009) research, which found that language and communication issues were the most significant challenge faced by refugees. The findings of his study indicated that there were

times when translation was so poor that in one case, child protective services became involved unnecessarily (Morris et al., 2009, p. 533-534). This finding is similar to an experience of one of the individuals in the present study, during which poor translation led to a family member receiving the wrong medication and becoming sicker.

Interviewees also discussed that when they were able to converse with providers without an interpreter, they sometimes felt unable to find a word in English that properly matched concepts in their heritage language. An important aspect of therapy is the ability for clients to be able to verbalize their feelings, and doing so often acts as a way for a client to feel witnessed and seen. It is understandable, then, why many feel that language presents a barrier to accessing and utilizing treatment. The results of this study, as well as the previous literature, support the need for quality translators, while also acknowledging that regardless of the quality, meaning, affect, and sometimes content will inevitably be lost or diminished due to language differences.

Alternative ways of coping. Although some of the participants in this study had utilized talk therapy and psychiatric medication for various mental illnesses, many had developed useful coping strategies that fall outside of the mental health system. One of the primary coping mechanisms involved utilizing community. For one participant, community was defined as going over to a friend's house and spending time together. About this she shared, "I go over her house, we talk, we laugh, we talk about my old friend, and all that kind of stuff". Talking, drinking, and laughing together were all mentioned by a number of participants as essential to the healing process. One participant found community through attending a women's group held at her workplace, where knitting, yoga, and other activities would take place on a weekly basis.

In Miriam George's (2010) research on theorizing refugee trauma, she posits that any understanding of the refugee experience must include Trauma Theory, which often places value

on healing mechanisms similar to what participants in this study mentioned, such as humor and socialization. Trauma Theory emphasizes the importance of utilizing the social aspects of one's life in the process of healing. (George, 2010, p. 382). The importance of community was also found in Betancourt et al.'s (2015) work exploring the utility of community-based participatory research. One finding of this study supported the notion that many refugees seek community support as essential to dealing with both past and present hardships. This previous research, as well as the findings of this study emphasize the importance of community support as an integral part of the healing process.

A group of coping mechanisms that were noted by two participants in this study, but not significantly present in the previous research, had to do with giving to others and possessing a sense of humility and gratitude for one's life. Two participants saw this as essential to getting through challenging times. For one individual, material donations, as well as kind words, were ways that she both connected with God and felt fulfilled. Another participant shared that he often reflects on the friends and family he has lost in the past, which fills him with gratitude and appreciation for being alive. He stated, "Surviving itself is a big thing, you know, a completion just to survive." For these participants, being humble and giving to others were essential to their well-being and played an important role in their process of healing. These were findings not present in the literature reviewed.

Suggestions for providers. Shannon et al. (2015) researched successful and unsuccessful referrals made by providers on behalf of refugees. One of the findings of their study notes the importance of establishing trust with the patient in order to have a successful referral. This is consistent with the research of the present study, during which two respondents shared that building trust needs to be a primary focus for providers at all levels in order to increase access to

and utilization of mental health services. One participant had gone to therapy and left shortly after because of the personal questions she was made to share before she felt trust was established with the clinician. Another individual mirrored this by sharing stories he had heard from some of his case management clients, who felt offended and deterred from treatment because of how quickly personal questions were asked. The previous research and this current study clarify the need for trust to be established between client and provider in order for mental health utilization to increase among refugees.

Better outreach was mentioned by participants in this study as a possible way to combat the lack of information and understanding many refugees have regarding mental health and mental health treatment. This was a finding not mentioned in the previous literature. One woman in the present study suggested that having informative events, sending flyers, or even knocking on people's doors might be useful ways to engage with the refugee community and inform them about mental health services. Participants who made this suggestion for providers felt that it could help with the lack of awareness many refugees have about services available to them, as well as helping to normalize and destigmatize mental illness and mental health treatment.

Case study: Fariha

This subsection will focus on a case study of one of the interviewees, who will be referred to as Fariha. Fariha's experiences and perspectives will be elaborated upon, as well as compared and contrasted with the experiences of the other participants. All information will be de-identified to maintain confidentiality.

Fariha, a Black, Muslim female-identified refugee, moved to the United States during her early adolescence in the mid-1990s. Before coming to the United States, she spent time living in two different countries in Africa. Fariha is married and has children, and does outreach work with refugees in Maine.

Fariha made clear that her religion is very important to her development and her understanding of the world, although her relationship to it has changed significantly over time. Fariha shared that growing up, she had an abusive father who was particularly aggressive in his teachings of Islam. She stated, “he was physically very aggressive, we have third degree burns, and broken bones, and loss of teeth and all that stuff, so - because that’s how he taught us the Quran.” She went on to say these early experiences shaped how she felt about men, her religion, and God: “I had a thing against men when I’m in the Mosque, I don’t feel, I don’t feel close to God, I feel a lot of resentment”. For Fariha, going to the Mosque and praying isn’t the primary way she connects with God now that she is an adult. Instead, she shared that she finds God “through nature” as well as through serving others and remaining humble. Her faith remains essential to her healing, her family, and her understanding of the world, although the role it has in her life changed over time.

Fariha is a self-identified extrovert and member of “Generation 1.5.. Neither here nor there” because she came to this country when she was still quite young. She is well aware of the silencing and stigma present in her community when it comes to mental illness, but remains vocal about her personal struggles with depression despite this: “I struggle in my community, I’m very vocal about it, so a lot of times people say, ‘Why do you always talk about your thing like that?’” Fariha has participated in talk therapy and psychiatry since she first arrived in the United States, and she supports its utility, while also acknowledging that it may not work for everyone. For her, however, her ability to overcome the stigma attached to mental illness and mental health treatment helped not only her, but one of her children who developed a panic disorder at a young age. Fariha brought her to therapy, which helped resolve her daughter’s anxiety. She shared “If I didn’t go through myself the mental health in this country and wasn’t so accepting, most likely I would be rushing my daughter every day to a Mosque”. This counters many of the accounts of the participants in my study who state that many refugees won’t seek out services, especially mothers who have children, for fear of losing them to Child Protective Services or similar systems. Fariha is aware of this fear, but it doesn’t dissuade her. She feels that this fear is largely due to a misunderstanding

of the government, and part of her work involves educating other refugees about these systems and their rights.

Another way in which Fariha defied many of the norms individuals in this study spoke of was in her political stances and how vocal she was about these. She noted the unique difficulties that accompany being a Muslim in America at this moment in time and how this acts a deterrent for many Muslims to share their mental health struggles for fear of appearing “homicidal”. She also is involved in the Black Lives Matter movement in Maine, and has her children participate as well. She is aware of the distance this can create between herself and her community. In some ways, this is a conscious choice. She noted that the distance serves as a coping mechanism at times, stating, “Staying away from my community, I work, I help them, but I like to distance myself, I don’t know. Being with other people outside of my culture, I find that I’m more authentic, being myself”. The individualism pervasive in the United States resonates with her: “In my culture there’s no boundary for personality, it’s a collectivism culture, so there isn’t individual. And I struggle with that, you struggle, it’s a culture that everybody identifies general to everything else, and you can’t find yourself.”

Fariha spoke openly about her abuse history, such as undergoing female circumcision, the pervasive sexism she saw in her home country as well as in her community here, and her father’s abuse, particularly when it came to teaching Islam. Despite this, she completed the interview by sharing that it was her father’s words that guided her during her most difficult times here: “I gotta tell you, when I came to United States, I swear to God the first thing that actually became guidance were his words. Even though at the same token I was going to therapy because of all the scarring he left behind.” She clarified that her father gave her freedom to be whoever she wanted to be, as long as she remained Muslim. She shared what she remembered of his lessons: “He said, ‘What I taught you today is for you to use later, it’s not for you to just be everything and anything I taught you today. But if you ever get lost, find your way home’”.

Fariha possesses a deep understanding of the barriers faced by refugees when it comes to accessing mental health services in the United States, as well as all the

personal struggles that are inherent to being Black, Muslim, a refugee, a woman, and a trauma survivor. Although she understands this, she does her best to live authentically, part of which is being vocal about her own struggles with mental illness, which takes great courage and creates distance between herself and her community. She openly shared her story, which is likely similar to the stories of many refugees. For this, she is a reminder of the importance of not accepting a sole narrative for the refugee experience. When the voices of a marginalized group are silenced, the experiences of members of that group often become dangerously and inaccurately generalized. Fariha's story growing up is similar to that of others who were interviewed in this study, but her adult life doesn't adhere to many of the norms described by individuals in various refugee communities in Maine, such as remaining silent about her mental health struggles and her experiences with seeking help. Even though it may isolate her from her community, Fariha speaks openly about her own struggles with mental illness in the hopes of normalizing a topic that is highly stigmatized in her culture. Many aspects of Fariha's case study are noteworthy departures from the findings, particularly how openly she speaks about her personal experiences with mental illness and mental health treatment. One of the most significant findings of this study indicated that the stigma around mental illness in many refugee communities is pervasive enough to force their members into silence. Fariha does the opposite of this in attempt to help others with struggles similar to hers. Her case study also differs from the findings when it comes to the way in which she interprets and incorporates her Muslim identity into her life. She problematizes some aspects of her religious faith and doesn't take its teachings at face value when they may interfere with her own mental health care or the mental health care of her children. Finally, although Fariha was aware of many of the fears that refugees confront when it comes to mental illness and mental health care among refugees, and despite possessing these fears herself at different points in her life, she was adamant about educating herself about her rights and putting her own mental wellness first. While this shouldn't be privileged as the best way to deal with the barriers elucidated in this study, she provides an example of a unique and authentic way of grappling with these barriers and finding an approach that works well for her and her family.

Strengths and Limitations

Strengths. This study sought to explore the barriers to mental health treatment for refugees in Maine. The voices of refugees, which are so often silenced, were imperative to amplify in this study. One of the primary advantages of qualitative research is its ability to capture a rich look at an individual's story. Rubin & Babbie (1989), when discussing the strengths of qualitative research, note "the chief strength of this method lies in the depth of understanding it may permit" (p. 361). Conducting 30-60 minute semi-structured interviews with the participants is a notable strength of this study, given the amount of individualized, rich data it yielded. Although the data collected cannot be generalized into a collective truth of the refugee experience, it offers a look into the truth that eight individuals carry regarding their own unique experiences. Additionally, the sample size of my study was small, but diverse in terms of the participants' countries of origin. Only three of the participants were born in the same country, and even then, they all carried unique migrant histories. The similarities among all eight participants, despite the variety in their countries of origin, speaks to potential commonalities within the refugee experiences regardless of birthplace.

Trustworthiness is a useful measure of the strength of a qualitative study. This concept encompasses reliability and validity, which refer to replicability of a study and the degree to which findings are correctly interpreted, respectively (Anastas, 1999, p. 415). Creating in vivo codes was used to help enhance the validity of the study. Ample raw data was also provided so that others can draw their own conclusions and judge the codes that were developed (Anastas, 1999, p. 427). Drisko (1997) discusses the concept of truthfulness, which emphasizes the believability of a study, stating, "Extensive reporting of raw data in the form of the participant's own words.. establishes credibility by allowing the reader to decide how accurately the

researcher has summarized and interpreted others' experiences, behaviors, and summarization" (p. 6). This was the objective in providing direct quotes from the research when presenting my findings and strengthened the believability of my interpretations.

Engel & Schutt (2013) note that unique to qualitative research is the focus on the whole rather than separate parts, and therefore "the social context of events, thoughts, and actions becomes essential for interpretation" (p. 303). The current political climate could be viewed as limitation regarding the effect it had on participant recruitment, but I believe it can be conceptualized as a strength given how monumental and transitional a moment our country is in. Particularly regarding policy around immigration, a collective tension and stress was felt during the data collection process. This offers a snapshot of how eight separate individuals, who arguably are some of the most affected by the current political climate, are experiencing this moment in time. This is an important strength of the study that should be mentioned.

Limitations. One of the primary limitations of this study is the small sample size. Data from eight participants, regardless of how in depth the data acquired may have been, is too small a sample to have any findings be generalizable. Anastas (1999) speaks to this challenge with qualitative data, sharing, "The degree to which the amount of the data analyzed can be reduced through sampling or quantification is quite limited because to do so would obviate the very purposes for which the research was originally designed" (p. 419). The main objective of qualitative research, with any sample size, is not to produce the most generalizable or statistically significant findings. That said, the sample size in the present study remains especially small, which is a notable limitation of the study. Additionally, six of the participants interviewed were female, which likely emphasized challenges faced by women refugees and de-emphasized the

unique challenges male refugees may face. The lack of diversity with regard to gender likely skewed the data that was obtained.

With all qualitative research, it is essential to reflect on the impact that the interviewer had on the data obtained (Anastas, 1999, p. 431). As much as one hopes to be unbiased and without presuppositions when collecting data, it's important to acknowledge the expectations that I inevitably carried when I collected data, particularly after having completed an extensive literature review on the topic. Additionally, there are stereotypes and biases about refugees that I have internalized simply from being a part of Westernized society. The lens through which I see the world undeniably influenced how I collected and interpreted the data. Engel & Schutt (2013) speak to this by sharing “a researcher is constructing a ‘reality’ with the interpretations of a text provided by the subjects of research: Other researchers, with different backgrounds, could come to markedly different conclusions” (p. 310).

My identity as a young, white, non-religious female student inevitably influenced the ways in which participants spoke with me, how much they felt comfortable confiding in me, and how they felt about the study as a whole. One of the defining characteristics of qualitative research is that no two researchers will acquire the same data, given that the interviewer is an instrument that has immeasurable influence on the data itself (Engel & Schutt, 2013). Considering that I am a white student asking people of color to share their attitudes about a system that disproportionately disadvantages people of color, it took special courage on the part of those interviewed to open up to me. In many ways, I am a part of that system and it is essential to reflect on how that may have limited the data acquired.

Implications for Practice and Policy

This section will discuss possible implications of this study for social work practice and policy. These implications will be broken down into the following subsections: providing

education/destigmatizing mental health, confronting language differences, increasing cultural awareness, and building trust.

Providing education/destigmatizing mental health. The need for better outreach and provision of education for refugees when it comes to mental health and mental health services were cited in much of the previous literature, as well as within the present study. In some cases, participants shared that they felt some of the underutilization of services was due to a lack of awareness that the services existed at all. For others, the stigma attached to mental health and mental illness acted as a barrier to accessing treatment. In both situations, education around services and education about mental health could be useful measures to combat the lack of awareness and stigma regarding this topic. Some of the participants in this study were already doing fantastic work to educate fellow refugees about their rights and what services were available to them. The findings of this study suggest that this awareness raising should be increased by resettlement agencies, primary care physicians, and any others who work with the refugee population. Outreach to refugee communities is absolutely necessary if utilization of services is to increase. Further, openly discussing mental health treatment would be a useful practice at these sites. Normalizing the use of talk therapy and psychiatric medication within this culture, while also conveying appreciation for what is risked when someone who identifies as a refugee engages with these services (feelings of shame, rejection from community), would be an advantageous practice.

Additionally, emphasizing and clarifying confidentiality would be a useful way to pacify the fear among many refugees that their personal stories will be shared with others, or even put their legal status in jeopardy. As was mentioned, women-identified refugees in particular spoke about the fear among many that one's children would be taken away from them if they carried a

mental health diagnosis. This misunderstanding must be dispelled at every stage of engagement with refugees in treatment, while also validating this fear and reality for some who have been abused by the system.

Confronting language differences. One finding of this study was that a shared experience exists among many refugees that some language translators are felt to be ineffective and often “just do it like for the sake of it”, as one participant expressed. It may, then, be worth exploring ways that training for translators could be improved. Perhaps developing ways to better monitor the efficacy of translators could be implemented to increase advocacy for refugees, who are forced to become dependent on the translator in these clinical encounters. One such way could be creating a feedback process in which refugees could share their thoughts and feelings about the degree to which a translator has correctly characterized their experience and made them feel heard and well-represented.

Tummala-narra (2016) discusses how one’s identity and one’s language are bound together, particularly for the immigrant and refugee population. She refers to language as a “transitional space through which one’s associations with the heritage culture and the new culture can be processed” (p. 51). She also offers some suggestions for how to incorporate one’s heritage language into the therapeutic space, even when the therapist may not understand the language that is being spoken. She often makes space for clients to share about their experiences in their heritage language, even when the therapist may not comprehend the words spoken. She finds that the affect in the room becomes more tangible and clear in this process, and the understanding and connection between therapist and client deepens in the process (2016, p. 120). While this may not be a useful practice during initial intake appointments when providers have

specific questions they need answered, this could be a useful technique to employ in psychotherapy with bilingual or multilingual clients who are struggling to express themselves.

It may, too, be of value for providers to explicitly acknowledge the reality that the meaning, affect, and sometimes content will be lost in the process of translation, whether it's through a hired translator or otherwise. This may mean that psychotherapy with a clinician that doesn't speak one's heritage language is not the best fit for some refugees. Verbal acknowledgment of this understanding to a client may be a helpful step in developing a therapeutic alliance and fully appreciating the unique challenges faced by individuals who don't speak English as their first language. Regardless of how it's confronted, it should be named, addressed, and appreciated where possible given the findings in the present study and previous literature that indicate that language differences are significant barriers in accessing mental health treatment.

Increasing cultural awareness. Considering the emphasis that the participants placed on the importance of cultural awareness, this is an area of practice in which there is room for improvement for all providers in the mental health field. In many ways, cultural competence trainings provided by one's workplace will likely not be fully sufficient to achieve proper cultural competence. For example, a training may inform providers of the importance of refraining from personal questions during the initial intake if possible, or at least explaining clearly that those questions are asked of every client and are not personal, as one participant in this study suggested. Another participant, however, spoke of the importance of learning specific cultural greetings or the belief systems typical of certain countries. These are details that won't be able to be covered in a one-time training, and may require providers to do some personal research when they encounter clients whose identities differ from their own. A commitment by

providers to take the time to engage in this research independently will likely make refugees feel more welcomed, understood, and valued as clients in mental health treatment.

Critical race theory offers a useful lens through which providers could meaningfully challenge institutional racism and deepen connections with clients. Critical race theory works to critique how racial power is imbedded in the legal system and at all institutional levels (Taliaferro et al., 2013, p. 37). While beyond the scope of full explanation here, critical race theory could be a useful launching off point for providers who wish to engage with anti-racism clinical work, given its particular focus on how the theory offers a shared language that can be used between provider and client when discussing race and racism in the United States.

Building trust. As with any client in mental health treatment, building trust is an essential component of an effective therapeutic alliance. The present study, as well as the previous research, specify the particular importance this carries when working with refugees. Being a refugee is a uniquely vulnerable identity to possess. A few participants in this study noted how this is made even more precarious by the current political climate, as well as the additional identity for some as a Muslim in post-9/11 America. Research indicates that the vast majority of refugees carry a trauma history with them upon arrival to the United States (Yakushko, 2010). The process of building trust can look a number of ways, and can be especially difficult to do with survivors of trauma (Herman, 1992).

One suggestion for how to do this better, which was mentioned by participants in the present study, would be to refrain from asking personal questions until a therapeutic alliance is better formed. Given the way our current mental health system is designed, clients are asked to share intimate details about their histories during intake sessions, and participants in this study noted the ways in which this can act as a deterrent to seek out or continue to use mental health services. There are institutional restraints and often obligations for providers to obtain some

information during the first intake session, but it may be worth exploring alternatives to this if mental health professionals hope to increase access to and utilization of services for refugees. This may require fundamental policy and practice changes within the mental health field.

Recommendations for Future Research

More research, particularly research amplifying and privileging voices of refugees, is needed on the topic of mental health utilization and access. Further research of this nature, with a larger sample size and more variety with regard to gender identity and racial identity, would be essential to broaden the scope of the research. This sample of this study included individuals from Africa and one country in the Middle East, and future studies on the topic would likely benefit from broadening the diversity regarding country of origin. Exploration of age at the time of resettlement and its influence on attitudes towards and utilization of mental health services would be an important variable to look at. A few participants in this study, especially those who were younger, noted the role generational differences play on the perception of mental health, but given the small scale of this study, no conclusions could be clearly drawn about this in the present study.

Conclusion

The research in this study indicates that barriers for refugees exist when it comes to accessing and utilizing mental health services in Maine. These barriers range from stigma and fear within one's community, to more practical barriers like language differences. While some of those interviewed had successfully accessed mental health services, some felt this wouldn't be useful to them and instead developed different coping strategies, such as connecting with one's community and maintaining an attitude of appreciation. Many felt that better outreach was

needed to provide education about and destigmatize mental health treatment in refugee communities and that providers could benefit from increasing their cultural awareness.

Refugees, or ‘New Mainers’, are an essential component of Maine’s community, and providers in the mental health field play a uniquely important role in helping make the difficult process of acculturation less challenging. Furthermore, many refugees carry trauma histories that compound the obstacles immigrants already have to face, making access to mental health treatment especially important. Finally, as with any potential client, it’s also important to accept that Western mental health treatment may not be the best option for everyone, and therefore respecting that decision and helping to support refugees in other ways may take precedence at times. As mental health professionals in a majority white state, particularly within the current political climate, we can do better by our New Mainers, and need to do better.

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Appendix
A

Interview Questions

Demographic Questions:

1. Where were you born?
2. At what age did you move to the United States?
3. Have you lived anywhere other than the country you were born in or the United States? If so, where?
4. How do you racially/ethnically identify?

Interview Questions:

1. What is your understanding of the available mental health treatment services here in Maine?
2. Do you have any personal experience with the type of mental health services you described?
 - a. If so, can you briefly describe what that experience was like for you? Feel free to be only as detailed as you feel comfortable being.
 - b. If not, can you imagine yourself seeking out the type of services you described earlier under any circumstances? What would those circumstances be?
 - i. Would you know where to go or how to go about receiving these services?
3. If/when you are experiencing emotional difficulties, such as sadness, worry, or feelings of anger, what are some of the things you do to make yourself feel better that are the most useful to you?
4. What do you feel are some of the greatest barriers for refugees when it comes to accessing mental health services in Maine?
5. Have you ever tried to get help but were discouraged for some reason? What was that reason?
6. Do you have any other thoughts on the subject that you would like to share?

Appendix

B

HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063

January 9, 2017

Hayley Fitzgerald

Dear Hayley,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Edmund'.

Appendix

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee
CC: Claudia Staberg, Research Advisor

C

Recruitment Letter

I am a student at Smith College School for Social Work and am conducting a study for my graduate thesis. I am in the process of looking for participants. If you do not meet the criteria to participate, it would be helpful if you know someone who might be eligible and interested in participating.

For my study, I am planning to interview 12 staff members who identify as refugees and are willing to express their opinions of and experiences with the mental health care system in Maine. There has been significant research showing that refugees often underutilize mental health services. I hope to work here in Maine when I graduate and I really care about this state, but I believe there is much room for improvement when it comes to understanding and addressing barriers to mental health treatment for many minority groups, and for this study specifically, individuals who identify as refugees. The interviews will be 30 minutes to one hour long and tape recorded with each individual's consent. The research will be entirely confidential and the findings will be de-identified.

Participants must be: Over the age of 18 years, identify as a refugee, be living in Maine, speak English fluently, and be willing to discuss perceptions of, relationship with, and attitudes toward mental health services in the state of Maine. Because I am a student with limited resources, no compensation is available.

If you are interested in participating, please contact me. If you know someone who may be interested in participating, or is a professional who may know where to locate participants, please have them call or email me. Thank you for your help!

Hayley Fitzgerald hfitzgerald@smith.edu
(xxx) xxx-xxxx

Appendix

APPENDIX D

Consent Form



SMITH COLLEGE

2016-2017

Consent to Participate in a Research Study Smith College School for Social Work • Northampton, MA

.....
Title of Study: Barriers to Mental Health Treatment for Refugees in Maine

Investigator(s): Fitzgerald, Hayley email: hfitzgerald@smith.edu
.....

Introduction

- You are being asked to be in a research study of the barriers to mental health treatment for refugees in Maine.
- You were selected as a possible participant because you identify as a refugee, are above the age of eighteen, speak English fluently, and you live in Maine.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.
- This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Purpose of Study

- The purpose of the study is to explore the barriers to mental health treatment for refugees in Maine.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: you will be interviewed by the researcher for no more than one hour. The interview will be audio recorded.

Risks/Discomforts of Being in this Study

- The study has the following risks. The questions asked in the study have the possibility of being emotionally distressing. You are welcome to refuse any questions asked or terminate the interview at any point.

Benefits of Being in the Study

- The benefits of participation are the opportunity to share your thoughts and views on the particular subject matter. Your voice and experiences are valued and essential to the research.

· The benefits to social work/society are: the findings from this study will be useful for social work and the Maine community by exploring better ways to provide mental health treatment for refugees in Maine. **Confidentiality**

· Your participation will be kept confidential. Once the data is collected through the interviews, all subsequent analysis will be completed with any names and identifying information being separated from the data. The link between the two will only be known to me, the researcher. The data and identifying information will be stored with me and only I will have access to it. Privacy will be ensured by conducting the interviews in a secure place without the likelihood of being overheard by others. No one in the agency, or its administrators, will know whether you've participated, nor will other staff/administrators see any information you've provided until it has been thoroughly disguised and unidentifiable.

· All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years in accordance with federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

· You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

· The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If this is an interview and you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by March 1st, 2017. After that date, your information will be part of the thesis.

Right to Ask Questions and Report Concerns

· You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Hayley Fitzgerald at hfitzgerald@smith.edu or by telephone at (xxx) xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974. **Consent**

· Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study

.....
Name of Participant (print): _____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____
.....

[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio] taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be {audio] taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____