

MENTAL HEALTH SERVICE DELIVERY FOR AFGHAN REFUGEES IN THE U.S.

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Abstract

Refugees are exposed to many stress factors that negatively impact their well-being prior to, during, and after resettlement that contribute to depression, anxiety, and somatization disorders (Abou-Saleh & Christodoulou, 2016). Refugees from war-torn countries, including Afghanistan, experience war trauma, as well as marginalization and discrimination in a new country, increasing the risk of depression and anxiety in refugees.

As of September 15, 2022, the total Afghan population in the U.S. was 189,493, with Afghan refugees arriving in four major waves--during the Soviet-Afghan War (1979–1989), during the Afghan Civil War (1990 to 1995), during the U.S./NATO intervention and fall of the Taliban (1996-2001), and during U.S./NATO withdrawal and resumption of power by Taliban forces in 2021 (Alemi, n.d.). Although research on 4th-wave refugees is limited, research on earlier waves found that the prevalence of mental health disorders among Afghan refugees was high (Alemi et al., 2016). Despite high prevalence, many refugees in the United States do not receive mental health care due to limited English-language skills, lack of awareness of services, reluctance to seek help due to cultural stigma around mental disorders, and negative attitudes towards and by providers (Satinsky et al., 2019). Research also suggests that education, income, and other factors influenced access to and utilization of mental health resources (Steele et al., 2007). Research suggests that mental health help-seeking among early-wave refugees is low (Abou-Saleh & Christodoulou, 2016). What is not known are the main barriers that prevent access to and utilization of mental health care in the most recent wave of Afghan refugees (Byrow et al., 2020).

The objective of this dissertation is to better understand the need for, access to, and use of mental health services among Afghan refugees in the U.S. Through three studies, I: 1) conducted

individual interviews with service providers to understand mental health needs of Afghan refugees in the U.S.; 2) conducted one-on-one interviews with Afghan refugees to determine the needs for mental health care and the barriers to accessing mental health services; and 3) administered a survey with Afghan refugees in two cities of Sacramento and Fremont in California to assess the influence of socioeconomic status (SES), sex, and years in the U.S. on mental health service use and knowledge.

Due to my recent refugee status from Afghanistan, I was uniquely qualified to conduct this research. The lawyer helping me with my personal asylum application established my connection with her friend who is lawyer in San Francisco. She connected me with the service providers and as well as with members of the U.S. Afghan community that assisted me in recruiting my samples.

The aim of my first study was to identify service providers' perspectives on the mental health needs and service use of Afghan refugees in the U.S. by conducting interviews with service providers. I completed interviews with nine service providers in January 2024. These service providers highlighted a number of barriers Afghan refugees face in accessing mental health services, including language barriers, cultural stigma, and a lack of knowledge about available resources. Furthermore, they emphasized the importance of providing culturally sensitive care and developing community-based support networks.

The aim of my second study was to identify refugee perceptions of supports and barriers to mental health in a sample of 20 adult Afghan refugees in two cities of California--Fremont and Sacramento. I found that language barriers, cultural stigmas surrounding mental health, financial constraints, and limited access to services all contributed to Afghan refugees' mental health issues. Those arriving since 2021 had better access to supportive services than those who came to

the U.S. in earlier waves. Participants who received services were very grateful for the assistance. They also recognized the importance of family, community, and faith-based coping mechanisms in addressing mental health issues.

The aim of my third study was to identify how socioeconomic status, sex, and years living in the U.S. influence mental health service utilization for Afghan refugees through quantitative surveys. Surveys were completed by 189 adults. I found that socioeconomic factors, such as household income in the U.S., significantly affected Afghan refugee mental health service utilization. Additionally, prior knowledge of mental health services and feelings of safety within the community were significant predictors of service use. Unexpectedly, neither sex nor years living in the U.S. were significantly associated with service utilization.

Taken together, the findings suggest that addressing the complex interplay of socioeconomic, cultural, and structural factors is essential in promoting mental health service utilization among Afghan refugees in the U.S. Based on these findings, recommendations for practice are outlined, including providing targeted support for refugees with limited financial resources, improving language-appropriate and culturally competent mental health services, and increasing awareness and outreach efforts within refugee communities. These findings also can be useful in shaping policy in the area of mental health services for refugees and helping design interventions that promote access to and utilization of mental health services for Afghan refugees in the U.S. Future researchers in this area should consider longitudinal studies, which would allow for follow-up of Afghan refugees who need mental health services, comparing outcomes among those that do and do not receive mental health services

Chapter 1. Introduction

Background

Refugees, Displaced Persons, and Asylum Seekers Worldwide

As a result of persecution, conflict, violence, or violations of human rights, many people have been forced to leave their homes worldwide. At the close of 2022, the global population of forcibly displaced individuals reached 108.4 million due to factors, such as persecution, conflict, violence, or human rights abuses. This figure comprise: 35.3 million refugees, 62.5 million internally displaced persons, 5.4 million asylum seekers, and 5.2 million individuals requiring international protection (UNHCR, 2022). By May 2023, the number of forcibly displaced individuals worldwide surpassed 110 million. This represents the largest annual increase in forced displacement recorded in the history of the UNHCR, driven primarily by the conflict in Ukraine and other deadly conflicts (UNHCR, 2022).

A refugee is an individual compelled to leave their home country due to persecution, conflict, or violence. They have a legitimate fear of persecution based on their race, religion, nationality, political beliefs, or membership in a specific social group. Typically, refugees are unable or afraid to return home. Major causes of their displacement include war and various forms of ethnic, tribal, and religious violence. Notably, over half of all refugees and others needing international protection originate from Syria, Ukraine, and Afghanistan (UNHCR, 2024).

In the U.S., a generally accepted definition of refugee by the United States Citizenship and Immigration Services (USCIS) is someone who can fall under the following criteria: country of origin outside of the United States; of special humanitarian concern to the United States; demonstrates that they were persecuted or fear persecution due to race, religion, nationality,

political opinion, or membership in a particular social group; is not firmly resettled in another country; and is admissible to the United States (USCIS, 2022).

Resettling refugees has been a U.S. priority since the 1970s, and the U.S. has the largest program in the world. Over three million refugees have been resettled in the U.S. since 1975, and their families have built new lives in every state. The Department of Homeland Security estimates that refugees from more than 60 countries have come to the U.S. since 2014 (National Immigration Forum, 2020). The U.S. Department of State and Homeland Security tracks refugees' arrivals by country of nationality from 60 countries (U.S. Department of State, 2023).

An internally displaced person (IDP) is someone who has been forced to abandon their home but remains within their country's borders. These people find refuge wherever possible—nearby towns, schools, settlements, camps within their country, or even remote areas like forests and fields. IDPs, often displaced by internal conflicts or natural disasters, form the largest group supported by the UNHCR. Unlike refugees, IDPs do not benefit from international legal protection or certain types of aid since they are still under the jurisdiction of their national government. Countries with significant IDP populations include Colombia, Syria, the Democratic Republic of the Congo, and Yemen (UNHCR, 2024).

An asylum seeker is someone who leaves their home country and seeks refuge in another country, applying for the right to be recognized as a refugee. This status provides them with legal protection and material assistance. To be granted asylum, they must prove that their fear of persecution in their home country is well-founded (UNHCR, 2024).

Mental Health Needs and Care Access

Due to premigration and postmigration stressors, as well as the difficulties they face along their journeys, refugees and asylum seekers are at risk of developing adverse mental health

outcomes (Salami et al., 2019). During the course of their lives, displaced persons are typically exposed to numerous traumatic events, often prolonged, repeated, and interpersonal in nature (Byrow et al., 2020).

It is likely that all three categories of people have experienced interpersonal violence, community violence, uncertainty about the future, personal or family persecution, and violent loss of loved ones during the displacement (Song & Teichholtz, n.d.). Then, upon arriving in the host country, refugees and asylum seekers face numerous new issues adjusting to the new environment, with limited social, cultural, moral financial support. They face post-migration stressors of poverty, insecure housing, unemployment, and multiple moves with changes in neighborhoods. They also struggle with isolation, stressful legal issues, poor access to services, discrimination and general disadvantages in the host country that can have a negative effect on their mental health (Song & Teichholtz, n.d.)

Studies on immigrants from predominantly Sub-Saharan Africa who immigrated to Sweden have provided critical information on pre-migrant trauma, post-migrant stress, and psychological sequelae (Steel et al., 2017). In comparison with females, men reported an increased frequency of traumatic events, like financial distress, discrimination, and healthcare issues, particularly related to financial stress, discrimination, and health care. In comparison to males, females reported higher prevalence of depressive symptoms.

Studies of refugees and asylum seekers have found that their mental health issues pose unprecedented challenges for countries of transition and resettlement who are tasked with assisting these vulnerable individuals to recover from the psychological effects of their experiences (Byrow et al., 2020). Based on literature and interviews conducted as part of a scoping review by Pollard and Howard (2021), political will and resources were major

challenges in UK. In general, public opinion and political is negative towards asylum seekers and refugees. According to interviewees, government funding for mental health services is not a priority, and mainstream services are not available (Pollard & Howard, 2021).

In the U.S., a systematic review was conducted by Byrow et al. (2020) to synthesize literature on refugee perceptions of mental health and barriers to mental health help-seeking. The findings from this study were classified into three domains: (1) cultural barriers (mental health stigma and knowledge of dominant models of mental health) (2) structural barriers (including financial strain, language proficiency, unstable accommodation, and a lack of understanding of how to access services), and (3) barriers specific to the refugee experience (immigration status, a lack of trust in authority figures and concerns about confidentiality) (Byrow et al., 2020).

According to other reviews, the most significant barriers to accessing care were limited ability to speak the language in the new country, poor help-seeking behaviors, a lack of awareness about mental health, stigma, and providers' negative attitudes (DeSa et al., 2022; Satinsky et al., 2019). In Canada, Salami et al. (2019) found that access to and utilization of mainstream mental health services among refugees were impacted by lack of mental health knowledge, stigma associated with mental illness in the countries of origin and in the local communities where they receive mental health services, and the high cost of accessing mental health services (Salami et al., 2019). Other barriers were high financial costs, transportation barriers, and childcare constraints. Women in Canada with limited socioeconomic resources, limited driving ability, and/or who were primary caregivers were particularly impacted by these barriers (Salami et al., 2019). Other barriers included the fact that public health insurance did not always cover community-based mental health services, there was a lack of flexibility in free services to meet refugees' complex needs, and few services were available in the evenings or on

weekends. For clients with low wages or precarious jobs who are primary breadwinners, taking time off was challenging. As a result of these barriers, immigrants and refugees unfamiliar with mainstream mental health services experienced significant delays in receiving support and addressing their mental health needs.

Afghan Refugees in the U.S.

Afghanistan has been experiencing instability, war, and political violence for over 40 years. More than 2.6 million Afghans have been settled in Iran and Pakistan, and thousands are scattered in approximately 70 other countries, including the U.S. (Alemi & Stempel, 2018). There are four waves of migration for Afghans. The first wave was during the Soviet-Afghan War (1979–1989), when 6 million Afghans were displaced. The second wave was during the Afghan Civil War (1990 to 1995) between Mujahideen factions, when vast numbers of Afghans fled to neighboring Iran and Pakistan. The third wave was during the U.S./NATO intervention and subsequent fall of the Taliban (1990 to 1995). The fourth wave followed U.S./NATO withdrawal, starting in 2021) and resumption of power by Taliban forces in 2021. In the most recent official population count, 190,389 Afghans lived in the U.S. As of May 2024, California stands out with the largest population, boasting a substantial 75,583 Afghan residents. Following California, Virginia has a significant population of 28,940. New York and Texas are nearly tied, with New York slightly ahead at 14,411 residents compared to Texas's 14,341. Washington has a notable population of 6,875, making it the next highest. Maryland's population is 4,815, placing it above New Jersey and Georgia, which have populations of 3,847 and 3,817, respectively. Massachusetts, with a population of 1,247, is followed by Nebraska at 1,089. Wyoming has the smallest population among the states listed, with only 6 residents (U.S. Census Bureau, 2020).

According to Alemi et al. (2014), there are a number of reasons why Afghan refugees are important to study. Due to Afghanistan's unstable sociopolitical situation, Afghans are constantly searching for better possibilities in neighboring countries and abroad, and Afghans are resettling in the U.S. at an unprecedented rate. Due to Afghanistan's weak mental health infrastructure, many Afghans have not received any psychological support previously. In addition, previous studies of migrant populations indicate that help-seeking behaviors are associated with culturally based explanations for mental health (Alemi et al., 2014). Although Afghanistan has a rich cultural and historical heritage, only limited research has been conducted on Afghan refugees' mental health. There is still a lot to learn about their needs and what is the most effective way to address them (Alemi et al., 2014).

Mental Health of Afghan Refugees

Research on this group shows that conditions leading to mental health issues and barriers to receiving mental health services are similar for Afghans as for other displaced people. For example, as a result of pre-migration traumatic experiences as well as post-resettlement factors, such as loss of social support, socioeconomic adjustment difficulties, and difficulty with immigration and asylum procedures,

Afghan refugees are highly distressed (Alemi & Stempel, 2018). A study by Alemi et al. (2014) showed that Afghans refugees resettled in industrialized nations are highly affected by psychological distress, such as depressive and posttraumatic symptomatology, as well as behavioral changes, nightmares, irritability, survivor's guilt, frustration, hopelessness, and sadness among their mental health concerns (Alemi et al., 2014). Prevalence of PTSD varies among Afghan refugees by locations, but previous studies suggest prevalence is high, with PTSD affecting 50% of Afghan refugees in the U.S., compared to 46% of Afghan refugees in Australia,

35% in the Netherlands, and 34% in the UK (Ahmad et al., 2020). Another study found that PTSD rates in Afghan refugee children reach up to 45%, but that fewer than 5% obtain specialist care (Rosenberg et al., 2022). Low maternal English proficiency was found to be associated with PTSD and major depression in refugee children.

In spite of this, little is known regarding the utilization or even favorability of professional psychological help for depression, anxiety, or PTSD among Afghan refugees (Alemi et al., 2016). A number of factors influence refugees' apprehensions about receiving professional psychological help, including Afghan refugee perceptions of suffering and illness etiology, distrust of Western medicine, lack of familiarity with Western medical methods, communication problems between physicians and patients, and practitioners' lack of cultural sensitivity (Alemi et al., 2016). Also, there is a limited understanding of how Afghan refugees perceive disorders such as depression in their culture, and an Afghan validation study of a culturally grounded mental health measure found that psychological distress may manifest as social withdrawal (e.g. self-isolation), somatic distress (e.g. headaches), ruminative sadness (thinking too much), and reactivity to stress (quarrelling with neighbors and/or family members) (Alemi et al., 2016). Although it is likely that Afghan refugees have similar issues with accessing mental health services as other refugee groups, there is little literature on the specific barriers faced by Afghan refugees today.

Suggestions for Improving Mental Health Service Use

In developing and delivering mental health services to refugees, culturally competent principles are most applicable. It also involves addressing differences in symptom expression that can bias diagnostic assessment, as well as factors that affect accessibility and acceptability, such as location, stigma, linguistic barriers, documentation and legal status, and cultural healing

modalities and practitioners (Pumariega et al., 2005). For example, Vietnamese immigrants tend to use Vietnamese-speaking physicians, Asian naturalists, spiritual healers, as well as psychiatric facilities and community mental health programs to treat their mental illness. In general, Mexican immigrants do not seek formal mental health services, instead opting to visit a primary care physician (Pumariega et al., 2005).

It has been found that cultural consultants with backgrounds in refugee communities are particularly effective at helping assess the need for mental health services and to improve service utilization and effectiveness. In addition to validation, mutual support, and processing their common experiences, approaches that address these needs have been found to be very effective (Pumariega et al., 2005). In addition to providing mental health and social services, refugees from diverse cultures need to be educated and assisted in understanding different cultural norms and practices in their new surroundings. Service providers also need to be educated about immigrants' traditional cultural practices (Pumariega et al., 2005). In this process, practices from their culture of origin that are negatively evaluated in mainstream American and Western culture are re-evaluated, for example, child abuse definitions and female genital mutilation practices (Pumariega et al., 2005). It also includes incorporating traditional cultural practices into Western-oriented mental health and health services to make them more acceptable to immigrants from a variety of cultures.

Dissertation Purpose

The purpose of this dissertation is to better understand the needs for, access to, and barriers to utilization of mental health services for Afghan refugees in the U.S. As part of my research, I interviewed refugee resettlement service providers who have helped Afghan refugees and are knowledgeable about their mental health issues (Study 1). I then conducted one on-one-

interviews with educated and uneducated, male and female Afghan refugees in the U.S. to identify issues and barriers associated with access to mental health services (Study 2). I then administered a close-ended questionnaire with 189 Afghan refugees to explore how their gender, socioeconomic (SES) status, level of education, and years in the U.S. influence mental health service awareness and utilization (Study 3).

Conceptual Framework

Two conceptual frameworks guide this study. The first, by Miller & Rasmussen (2016), displays the numerous domains that cause distress among refugees. These include pre-migration effects of violent, terrifying, and heartbreaking experiences in their home countries. In addition, there are post-migration stressors, such as poverty, unemployment, social isolation, and housing difficulties (Miller & Rasmussen, 2016). This conceptual framework serves to explain the variety of stressors Afghan refugees likely to be in my studies experience (Figure 1.1).

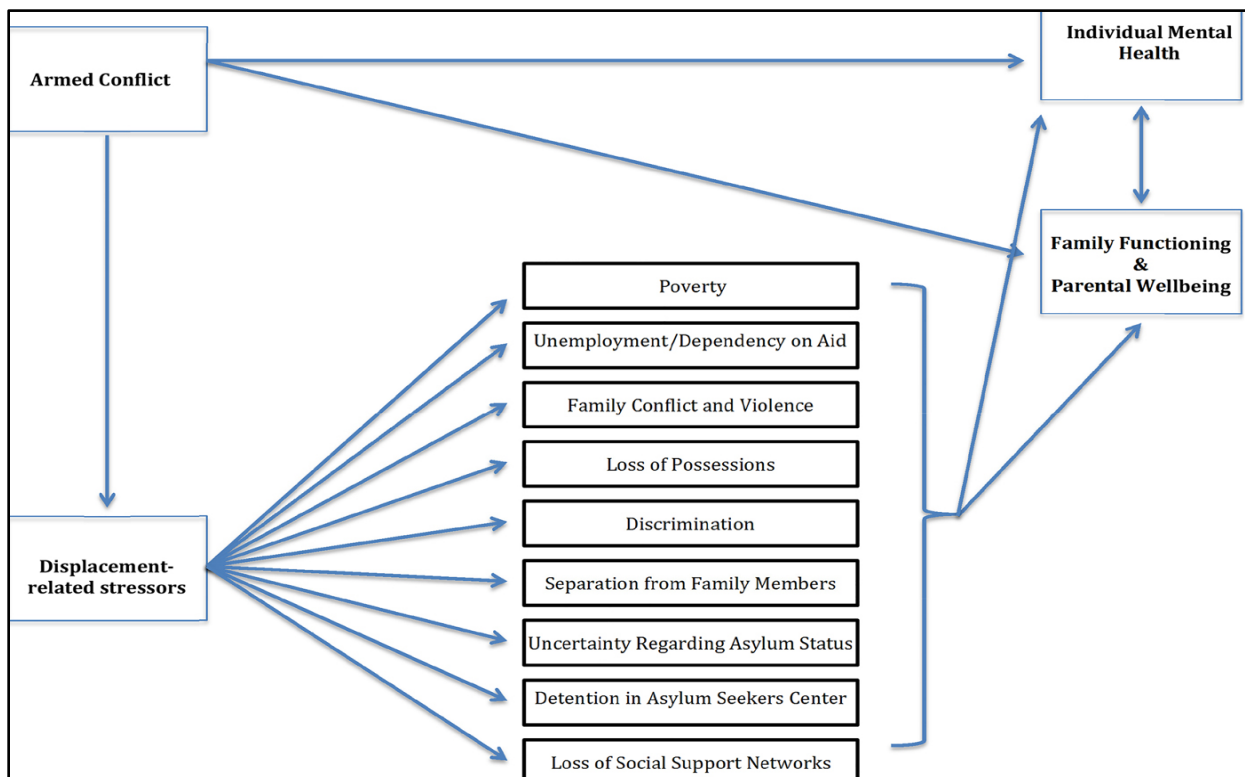


Figure 1.1. Armed Conflict, Displacement and Mental Health (Miller & Rasmussen, 2016)

The second framework focuses specifically on mental health service use facilitators and barriers of Afghan refugees in the U.S. (Figure 1.2). It was developed based on research by Goodkind et al. (2014) and Webb et al. (2021) to display barriers and facilitators to mental health care access by ecological level – societal, interpersonal, and individual. These barriers, in turn, need to be addressed through a multi-service approach that includes individual and family resettlement assistance, case management, therapy and perhaps even psychiatric medication.

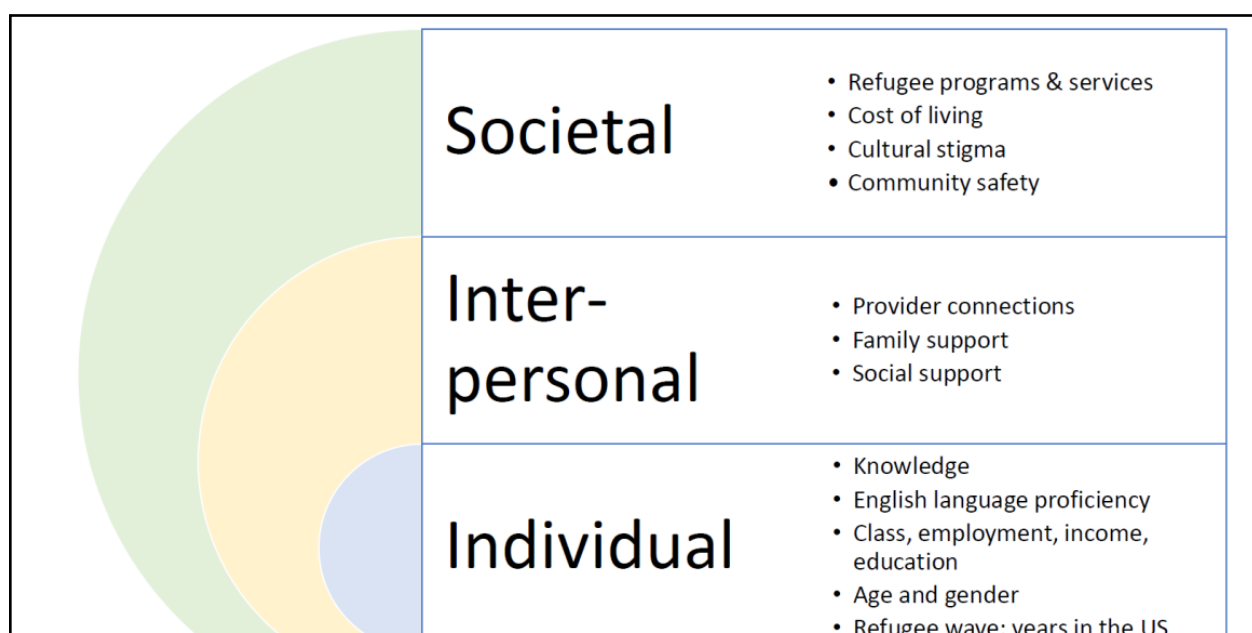


Figure 1.2. Ecological Model of Barriers to and Facilitators of Mental Health Service Use Among Afghan Refugees in the U.S.

Specific Aims

The first specific aim was to identify service providers’ perspectives on the mental health needs and service use of Afghan refugees in the U.S. by conducting interviews with service providers. I expected the service providers had specific and unique knowledge about the mental health needs and service utilization patterns of Afghan refugees.

The second specific aim was to identify refugee perceptions of supports and barriers to seeking professional help to relieve anxiety, depression, and stress by interviewing Afghan refugees about mental health issues and service use. I expected to see cultural beliefs and stigma as significant barriers to good mental health and service use for Afghan refugees.

The third specific aim was to identify how SES, sex, and years living in the U.S. influence mental health service utilization for Afghan refugees by quantitatively surveying adult refugees. I expected to see refugees with higher education, income, female gender, and more years living in the U.S. more likely to use services.

Positionality

I am a recent refugee from Afghanistan, so I understand how the stresses of relocation, loss of status, and other issues can damage one's mental health. I also have studied in the U.S. and have knowledge of U.S. recognition that mental health is important and that issues can be addressed. In addition, I possess experience in addressing mental health issues in Afghanistan, and I am intimately familiar with Afghan culture that has a lot of taboos around recognizing and talking about mental health issues.

Community Partners

I was able to identify organizations in California that assist refugees from Afghanistan, including non-profits organizations, coalitions, mosques, and grocery stores. They helped me identify providers serving Afghan refugees in Oakland, Alameda, Concord, Sacramento, and the Fremont area. My contacts at these organizations also helped me identify Afghan refugees in Fremont and Sacramento to interview for Study 2, as well as Afghan refugees from anywhere in California for my Study 3 survey.

Chapter 2. Provider Perceptions of Afghan Refugee Mental Health Needs and Access Issues: A Qualitative Study

Introduction

Being a refugee is generally associated with high rates of mental health problems due to the traumatic experiences refugees encounter prior to leaving their home countries, during their journeys to a new country, and then adjusting to a new community (Pumariega et al., 2005). The most commonly reported problems among adults are depression, anxiety, and post-traumatic stress disorders. Several factors contribute to this vulnerability, including a refugee's traditionalism and cultural inflexibility, linguistic barriers, a lack of family and social support, and physical limitations (Pumariega et al., 2005).

The U.S. provides a range of services to assist resettled refugees in meeting basic needs and integrating into the society. Operation Allies Refuge was launched by the U.S. government to expedite the admission and resettlement of individuals who had worked for or on behalf of the U.S. in Afghanistan, granting them Special Immigrant Visas (SIV) or Special Immigrant Paroles (SI/SQ).

In the U.S., the refugee-resettlement program is coordinated through collaboration between the UNHCR, U.S. government agencies, non-governmental organizations, and other entities. Among the national government partners are the U.S. Department of Homeland Security: Citizenship and Immigration Services (USCIS); the U.S. Department of State: Bureau of Population, Refugees, and Migration (PRM); and the U.S. Department of Health and Human Services: Office of Refugee Resettlement (ORR). They collaborate with State Refugee Coordinators and State Health Coordinators.

Several prominent non-governmental partners and refugee-advocacy organizations, such as Refugee Council USA (RCUSA), InterAction, and Cultural Orientation Resource Exchange (CORE), are involved. Resettlement agencies include Church World Service (CWS), Ethiopian Community Development Council (ECDC), Episcopal Migration Ministries (EMM), Hebrew Immigrant Aid Society (HIAS), International Rescue Committee (IRC), the U.S. Committee for Refugees and Immigrants (USCRI), Lutheran Immigration and Refugee Services (LIRS), the U.S. Conference of Catholic Bishops (USCCB), and the World Relief Corporation (WR).

Each resettlement agency has its own method for identifying refugees in need of mental health services. For instance, a contact at the Refugee Services Jewish Family & Community Services East Bay agency explained that, upon arrival, refugees undergo assessments for their needs, including mental health issues, conducted by a case worker. The agency employs clinicians who offer temporary on-site services, and they can also refer refugees to other mental health services and therapy agencies.

Information from refugee service providers can shed light on the mental health needs and barriers to service use. For example, in a study in Canada, Salami and colleagues (2019) gathered qualitative data on accessibility and use of mental health services among refugees from 53 providers recruited from nine immigrant serving agencies. A main findings of the study was the difficulties faced by immigrants to understand, access, and utilize mental health services in Alberta (Salami et al., 2019).

In the U.S., interviews with Tennessee-based service providers indicate that refugees needed a wide range of integrated and comprehensive services at the primary and community care levels (Forrest-Bank et al., 2019). The authors emphasized the need for more training on cultural competence and to engage with refugee youth in the context of their families,

communities, and groups, rather than to offer individual counseling. They also stressed the importance of developing trusting, meaningful, and long-lasting relationships with immigrant patients (Forrest-Bank et al., 2019). Providers recommended that organizations be flexible with their time and resources to develop trust and meet needs, have good interpreting services, and work in concert with families and social services.

Given that only a single study of the perceptions of U.S. based refugee service providers was found, and none focused specifically related to Afghans refugees, I interviewed service providers to identify the barriers and facilitators associated with mental health services use in this population.

Methods

Study Design

The study employed qualitative methods. Specifically, I interviewed service providers about mental health needs and service use among Afghan refugees in the U.S.

Sample

A sample of nine service providers from Oakland, Alameda, Concord, and Sacramento was recruited through direct email invitations to participate in the study. These communities were selected because they host large clusters of Afghan refugees, and providers were identified during my visit to California in March 2023. To be eligible for the study, service providers needed to have direct contact with Afghan refugees from any of the waves and to have offered some form of mental health services to Afghan refugees as part of the resettlement process or afterward.

Research Ethics

University of Hawai‘i Institutional Review Board approval was obtained for this study. Participants in the study were informed of the purpose and potential risks of the research through the consent form (Appendix A). It was acknowledged that some participants might feel uncomfortable or stressed when answering certain interview questions. They were assured that they could choose to skip questions, end the interview, or withdraw from the study at any time.

Additionally, they were informed of the measures taken to ensure the confidentiality of collected data. Specifically, upon enrollment, participants were assigned a unique identification number. Any information pertaining to the study participants and their identification number was stored on a secure, password-protected computer accessible only to the principal investigator. All collected information was used solely for the purpose of this study. Upon completion, participants were asked if they would like a copy of the study findings. The names of interested individuals were recorded separately from demographic information, consent forms, and responses.

Measures

Those who agreed to participate and completed the consent form was sent a questionnaire to solicit demographic information, including ethnicity, language, occupation, organization, and the percentage of mental health clients they’ve seen from Afghanistan from each wave (Table 2.1). These data were used to describe the sample.

Table 2.1. Study 1 Demographics

Questions	Response Options
Are you Afghan?	Yes or no
What languages do you speak?	Pashto, Dari, English, other
What is your role in the organization?	Case worker, psychiatrist or psychologist administrator, other

To your best estimate what percentage of Afghan clients are in each of the four waves?	Wave1 (1979–1989) Wave2 (1990 to 1995) Wave3 (1996-2001) Wave4 2021-present
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As noted in the introduction, the first wave was during the Soviet-Afghan War (1979–1989), when 6 million Afghan were displaced. The second wave was during the Afghan Civil War (1990 to 1995) between Mujahideen factions, when vast numbers of Afghans fled to neighboring Iran and Pakistan. The third wave was during the U.S./NATO intervention and subsequent fall of the Taliban (1990 to 1995). The fourth wave followed U.S./NATO withdrawal and resumption of power by Taliban forces in 2021. In the most recent official population count, 190,89 Afghans lived in the U.S., with 3,523 living in Fremont, and 19,741 living in Sacramento (U.S. Census Bureau, 2020).

The interview questions also were shared via email. During the interview, mental health service providers were asked questions about Afghan refugee mental health needs and access in the U.S. (Table 2.2).

Table 2.2. Study 1 Interview Questions and Measures

Level	Category	Question
	Experience	Please share your experience working with Afghan refugees.
Individual	Needs	What individual needs do refugees have?
Interpersonal	Needs	What interpersonal needs do refugees have?
Societal	Needs	What societal needs do refugees have?
All	Needs	What needs are different in Afghan refugees compared to other clients?
Individual	Needs	What are the common mental health needs of refugees?
All	Needs	What is preventing good mental health in refugees?
Societal	Culture	How does culture play a role in receiving mental health services?
All	Access	What mental health services are available for Afghan refugees?
All	Access	What barriers are preventing refugees from receiving mental health services?

All	Assessment	How do you decide when a refugee needs mental health services?
All	Treatment	What treatment plans are commonly recommended to Afghan refugees?
All	Treatment	What barriers are preventing refugees from adhering to treatment plans?
All	Conclusion	Please share an example of how you helped a refugee overcome a barrier in access, assessment, or treatment.

Procedures

Following informed consent procedures, interviews were conducted via Zoom and phone calls. Each interview was scheduled for approximately 60 minutes, conducted by the researcher. However, phone interviews typically lasted 1.5 hours. All interviews were conducted in English, as all service providers were fluent in the language. With their permission, interviews were audio recorded.

Interview Analysis

The interview transcripts were cleaned, and the researcher identified emerging issues related to perceptions of the need for and barriers to mental health services for Afghan refugees. Codes and themes were managed using an Excel spreadsheet created by the researcher. Dr. Kathryn Braun, the dissertation committee chairperson, assisted in confirming codes and themes.

Results

Characteristics of the Sample

The sample included nine mental health service providers; 5 were male and 4 were females. All were of Afghan heritage. These service providers offered mental health services in four counties of California: Alameda, Concord, Sacramento, and Oakland. Services provided included assessment and referral, education, programs, individual therapy and counseling,

marital counseling, and family therapy and counseling. Their titles included case manager, health navigator, licensed provider, and clinical psychologist.

The percentage of clients from each of the four waves of immigration varied by provider. In general, however, about 10% of clients were from the first wave, reflecting the enduring impact of the Soviet Afghan War. About 20% of clients were from the second wave during the Afghan civil war, and another 20% from the third with arrival of NATO forces. Refugees from the fourth wave, which began in 2021, account for the largest proportion of clients, about 50% of clients seeking support as they navigate the challenges of resettlement and adjustment in their new homeland. However, one mental health service provider mentioned that significant trend in clientele, with most new clients belonging to Wave 4. Another said, “the majority of our clients began seeking assistance in 2021 (Wave 4), and this trend continues to the present day.”

Themes

There were three major themes: 1) factors that led to refugees’ mental health issues; 2) common treatment plans once in the U.S.; and 3) barriers to mental health services.

Theme 1: Factors that led to mental health issues.

All nine service providers spoke about challenges their clients experienced that caused them mental distress. For example, five providers talked about trauma that stemmed from Afghan refugees’ “experiences of war, violence, persecution, and the trauma of fleeing their home country.” Another provider talked about the ongoing stress associated with “uncertainty about the future, concerns about family members left behind, and experiences during the journey.”

Added to the stress of fleeing their countries, all nine service providers talked about the stresses experienced in the U.S. and the “disparities in cultural norms that presented notable

obstacles for Afghans who settle in the U.S. as they manage everyday tasks.” As one provider said, “Afghans who settle in the U.S. frequently seek to assimilate into American society while preserving their cultural heritage. Striking a balance between these aspirations can lead to feelings of stress and anxiety.”

All nine providers also talked about the stress associated with limited ability to communicate effectively in a new language and a lack of Dari and Pashto speakers in the U.S. This stress is compounded by the fact that many refugees, especially women, cannot read or write in any language. As one service provider said, “difficulties in communicating in a new language can lead to misunderstandings and isolation, compounding stress and anxiety.” The intricate journey of acquiring refugee status and maneuvering through legal frameworks can prove intricate and daunting for Afghan refugees, exacerbating their mental health challenges. Four service providers spoke specifically about legal and documentation challenges in getting refugee status, as illustrated by this quote: “The uncertainty surrounding legal status, asylum processes, and fear of deportation can cause significant anxiety and stress.”

Three service providers spoke about the challenges with employment, including “a lack of opportunities for employment and income generation, particularly in the initial phases of resettlement” and low “financial assistance or subsidies.” They also noted that a lack of a stable, long-term living situation was a cause of “stress, anger management issues, or depression.”

In addition to language, service providers identified how cultural differences between Afghanistan and the U.S. can cause mental distress. For example, some are stressed about admitting they are distressed because they are “stigmatized as mentally ill or weak,” which is a problem in “small, close-knit refugee communities.”

Theme 2: Common treatment plans once in the U.S.

In response to the question about common treatment plans for Afghan refugees, providers noted “an increase in the availability of mental health services as a result of the recent events in Afghanistan.” It was noted that many nonprofit organizations were offering mental health counseling and therapy to Afghan refugees, with greater availability in communities where Afghans tend to cluster, like in California. Types of available services included psychoeducation, individual, family, peer, and group therapy, as well as medication and complementary and alternative approaches. As one provider said, “the starting point for any approach is psychoeducation and awareness. Then cognitive-behavioral therapy or CBT seems to be the most effective method of treatment for the Afghan population...followed by group or peer therapy in the community.”

Providers emphasized the importance of psychoeducation, stressing the need for “educating refugees about common mental health issues, stress management techniques, and coping strategies.” As one provider said, “increasing awareness and education about mental health symptoms, signs, and illnesses are fundamental needs for Afghan refugees due to exposure to many years of war and violence and the existence of stigma.” Other important services included “community-based psychosocial interventions that focus on building social support networks, reducing isolation, and fostering a sense of community” and, “group therapy or support groups that provide opportunities for shared experiences and mutual support.”

More serious cases are treated with medication and individual therapy. Complementary and alternative approaches also were used. As one mental health service provider said:

So, you know, medication is definitely something I’ve seen a lot of people start with, and then they move on to talk therapy. I think those two are usually the common ways of

treating certain mental health conditions. When I refer them to therapy, they receive different types of support. Sometimes it's cognitive behavioral therapy; some of it is biofeedback, although there aren't many providers for that. Cognitive behavioral therapy involves having discussions about reframing the way they process an event. Those things can be helpful. And then I also refer a lot of my families to acupuncture, which seems to be helpful, especially if they have physical manifestations of their mental health, like shoulder pain, back pain, or other types of pain. Sometimes, I'll try acupuncture to see if that helps.

Trauma-informed care was mentioned as important, as noted by a provider "Some of our implementing partners are providing mental health services to specifically address trauma, such as counseling and therapy for PTSD, which is common due to experiences of war and displacement."

Providers underscored the importance of cultural competency in delivering mental health services to Afghan refugees. Preferences for Afghan providers, services offered in primary languages such as Pashto and Dari, and providers' understanding of Afghan culture and traditions were identified as critical factors in establishing trust and facilitating effective therapeutic relationships. One provider added that there is a "female provider preference for Afghan women," as well as "services in the primary languages, and providers' competency in Afghan culture and traditions." Another noted that "some of our partners are providing mental health services via online platforms or telehealth, which can increase accessibility for those who face transportation or mobility barriers."

Seven providers stressed the importance of community programs, organizations serving Afghan families, and women's groups organized by refugee resettlement agencies in refugee mental health. These can offer "peer mental health support." One said,

There are a few community programs that I like, and I have contacts at several community organizations that work specifically with Afghan families. These are usually the organizations to which I refer my families. They provide them with the necessary information. Some of these programs have therapists who speak Dari or Pashto, so I often refer my patients to them. Additionally, there are many refugee resettlement agencies and refugee groups organize women's groups where they can gather and ask questions. These groups have been very helpful. Connecting them to these resources can be beneficial because it gives them a sense of community involvement. Sometimes, I also refer them to their local mosque to see if there are any support groups available there.

Additionally, they emphasized the role of contact persons as liaisons between agencies and community members, as illustrated by this quote:

Contact person acts as a liaison between the agency and the community members. Their role extends beyond mental health services to include assistance with various tasks such as filling out forms or applying for food stamps and other social services. Initially, they establish connections with community members through these activities. As they recognize a greater need for services, they can then initiate conversations, particularly about mental health.

Five providers highlighted the important process of working closely with individuals to develop treatment plans aimed at resolving or mitigating these issues, thereby empowering them to actively participate in their communities and work towards their goals. One said,

“involvement in decision-making processes or community groups can empower them and give a sense of agency.” These treatment plans typically include strategies to increase self-esteem, reduce anxiety and depression, and promote an active lifestyle, as stated in this quote:

Oftentimes, as I mentioned, family issues or personnel issues in terms of like stress or anger management issues or depression and working with them closely to develop a treatment plan, which includes resolving the issue, obviously, or at least contributing, decreasing the level of stress or depressed depression that they are feeling. Increasing, they’re basically empowering them to become more active, and active participants have the community help them work towards their goals. For individuals that I work with, I am empowering them, increasing their self-esteem, and promoting an active lifestyle. This helps them to lower their anxiety and depressed mood.”

Theme 3: Barriers to Receiving Mental Health Services

Service providers spoke of two major challenges for Afghan refugees in getting mental health services. The first included barriers imposed by Afghan culture and how these varied by the client’s sex, education level, and length of time in the United States. For example, a provider said, “one of the biggest barriers, as I mentioned, is the cultural differences and the cultural perspective on mental health.” Another said noted “lack of awareness of mental health problems, language barriers, [and] stigma to be problematic.” Two others said that refugees were generally unaware of mental health issues. In talking about cultural barriers, a provider said, “there are mainly two main factors. One is the level of motivation and trust of the refugee towards the mental health system, two is the level of availability of clinicians who are familiar with the culture.” Another said the stigma was the greatest barrier since many Afghan refugees feel that “only crazy people see mental health professionals.” Another provider noted:

I believe culture plays a major role in mental health stigma, particularly in developed and developing countries. Culture influences how mental health challenges and issues are perceived and discussed. Oftentimes, Afghans simply deny or shy away from discussing mental health due to its taboo nature in Afghan culture. Many Afghans understand mental health challenges using terms like “crazy” and may refuse mental health services because they do not want to be associated with that label.

Providers also realized that Afghan refugee mental health needs can be better understood and met by providers with similar cultural backgrounds. Trust between patients and providers can be enhanced when providers are familiar with cultural nuances, idioms of distress, and traditional healing practices. According to the following quote, this is illustrated:

Culture is significant in receiving mental health services. Research indicates that providers from the same culture and background better deliver mental health services than other cultures. Knowing culture can build trust between a patient and a provider. A culturally competent provider will understand better the mental health needs of Afghan refugees. For example, most Afghan refugees express their depression as *jigar khun*, which translates to “bleeding liver.” Afghan refugees often describe anxiety or nervousness as *fishar-e-baallaa*, which translates to “high blood pressure. Understanding the idiom of distress in Afghan refugees can help prevent misdiagnosis and mistreatment.”

Level of education also shapes Afghan refugee attitudes towards mental health support. Individuals with a higher level of education are often more open to seeking mental health services and engaging with them, and some may also have prior mental health experience with mental health programs. As one provider said:

Do I see a pattern between educated and uneducated Afghans in terms of receiving mental health support? Absolutely, yes, absolutely. As mentioned before, culture plays a significant role, but so does education, particularly among newcomers. Last year, when I worked with them, especially young, educated individuals, I observed a notable difference. We have a system, as I mentioned earlier, where outreach workers engage with people personally to determine if they need mental health services. Individuals with lower levels of education often either deny the need for help or disagree with the services provided, believing they are unnecessary. In contrast, those with higher levels of education are more proactive. They seek out my colleagues themselves, asking how they can enroll in mental health programs. I was pleasantly surprised to learn that many of these educated individuals had prior experience with psychologists in Afghanistan or online with Iranians, indicating they have received mental health support before. Thus, there is a noticeable difference in attitudes towards mental health support based on education level.

Providers also spoke about differences in service use based on the amount of time the refugee has been in the United States. A provider explained:

In terms of challenges, I have observed differences based on their arrival time. With newer arrivals, I see more possibilities in terms of service providers offering services in different languages for Afghans, compared to those who have been here for a while. Previously, there was limited funding available for mental health services, and not many agencies focused on providing services to the Afghan community.

A barrier related to culture is their inability to speak English. A service provider said: “lack of proficiency in the host country’s language can make it difficult for refugees to

communicate their needs and understand mental health services. Limited availability of interpreters or translated materials can exacerbate these communication challenges.” Because of this, it is difficult from them to gain “knowledge of the U.S. healthcare system...understand the prescription refilling process [and] understand medication common versus abnormal side effects,” making it difficult to adhere to treatment plans.

Another area of challenge included limited availability of Pashto- and Dari-speaking providers and translated materials, and the difficulty engaging in therapy through an interpreter. As one provider said,

Not all Afghan refugees are interested in counseling and cognitive therapy. The reason for the low interest in therapy services is that the services are not provided by the Pashto and Dari-speaking providers. Also, non-Afghan providers need to become more familiar with the culture and background of the Afghan refugees; therefore, the connection, trust, and relationships are not very strong. On the other hand, providing therapy through interpreters is also not very effective because of the lack of direct communication and interaction between the patient and the provider which is important in mental health therapy.

Other barriers noted by providers were common to many groups, including missing or inadequate health insurance coverage, long wait times to see a provider, family lack of support for treatment, and lack of routine communication between patients and providers. Providers also talked about how refugees often face multiple barriers that compound the program and further limit their ability to access services. A provider said:

Lack of awareness of mental health problems, language barriers, stigma, not understanding the U.S. medical system, low literacy, culture of shame, no insurance,

underinsurance, lack of providers from the same culture, and long wait times to access mental health services...All are preventing good mental health in Afghan refugees.

Several providers stressed that refugees' needs are dynamic over the course of integration and resettlement. In addition to their mental health needs, programs must assure that their physical health are met. Additionally, refugees need help with legal issues, education in English language and American culture, and with securing adequate shelter and income. As a provider noted, "As refugees undergo various stages of integration and resettlement, their shifting needs require a holistic approach to ensuring their success." Also, families of refugees need to be assisted in locating and reuniting with their loved ones, and social networks and community connections should be fostered for them to feel less isolated and lonely. Another provider said, "addressing the diverse needs of refugees requires a collaborative approach involving different stakeholders and sectors."

Discussion

The findings about the mental health needs and challenges faced by Afghan refugees, resettled in the U.S. include trauma, cultural adjustment, linguistic barriers, limited social support, and legal uncertainty, and these findings agree with those in the literature (Pumariaga et al., 2005). This study's findings on the importance of culturally appropriate, integrated mental health services for refugee populations are also similar to those found by other researchers (Salami et al., 2019). There is broad agreement that Afghan refugees' mental health needs should be addressed through tailored interventions, culturally competent care, and community-based support.

Although the results of this study largely support existing literature on refugee mental health, the interviews with service providers revealed some nuances and additional insights. As

an example, the study highlights the importance of understanding Afghan refugees' attitudes toward mental health support based on factors such as their education level and time spent in the U.S. Moreover, this study emphasized the importance of holistic support beyond mental health services alone to support refugee needs during resettlement and integration. The existing literature mainly focuses on mental health interventions, but this study addresses broader socioeconomic, legal, and political challenges affecting refugee well-being.

Strengths and Limitations

There are several strengths to this study. First, a qualitative approach was used to explore mental health service providers' perceptions and experiences. As part of the study, a diverse group of mental health service providers in California were interviewed, providing a comprehensive look at Afghan refugee mental health services.

The study was limited, however, by a small sample size of nine providers, as many providers who were approached were too busy to be interviewed. The study was conducted in California, and interviewees acknowledged that different states have different service delivery systems. Data were self-reported by service providers, so social desirability bias and memory errors could have affected the outcome. Finally, the study is qualitative, preventing causal inferences or generalizations to other settings besides Afghan refugee mental health.

Recommendations

Based on the findings of this study, several recommendations can be made to improve mental health services for Afghan refugees in the U.S. First, to better understand the needs, beliefs, and preferences of Afghan refugees, mental health providers should receive cultural competency training that discusses cultural norms, idioms of distress, and traditional healing practices. Second, Pashto and Dari are two languages spoken by Afghan refugees, so is

necessary to increase the availability of mental health services in those languages. Relatedly, it is essential to use bilingual providers and interpreters to facilitate effective communication and engagement with refugee clients. Third, culturally responsive mental health programs and support networks for Afghan refugees need to be developed in collaboration with community organizations, refugee resettlement agencies, and religious institutions. Fourth, programs need to help promote help-seeking behaviors and reduce stigma associated with mental health issues. Programs also are needed to address barriers Afghan refugees face in accessing healthcare, education, employment, housing, and legal assistance.

Further research should be conducted on the long-term impact of mental health interventions on Afghan refugees as well as service utilization patterns. The complex dynamics of refugee mental health and resilience can be better understood through longitudinal studies and mixed-methods research designs.

Implementing these recommendations can help mental health practitioners, policymakers, and community stakeholders enhance Afghan refugee mental health services in the U.S in terms of quality, accessibility, and responsiveness.

Chapter 3. Experiences of Afghan Refugees in the U.S. and their Mental Health Services

Use: A Qualitative Study

Introduction

Afghan refugees are the second-largest group of refugees in the globe, with 2.5 million registered cases worldwide (Reihani et al., 2021). Since the Refugees Health Act of 1980, more than three million refugees have been relocated in the U.S. According to the American Community Survey administered in 2022, 189,493 Afghans live in the U.S. (U.S. Census Bureau, 2022).

Afghanistan residents have experienced decades of war and instability, and researchers have identified four waves of Afghan refugees in the U.S. There were several migration waves in Afghanistan's turbulent history, each marked by distinct circumstances. Wave 1 (1979–1989) emerged after the Soviet-Afghan War. Wave 2 (1990 to 1995) occurred following the withdrawal of Soviet forces and during the Afghan Civil War. Wave 3 (1996-2001) occurred during the Taliban's reign. Wave 4 (2021-present) occurred followed the withdrawal of U.S./NATO forces and the rise of the Taliban. The Special Immigrant Visa (SIV) program facilitated the resettlement of thousands of Afghans in the U.S.

Refugees experience significant mental health issues due to their experiences in their home countries, including war and instability, which underscores the need for effective mental health interventions (Byrow et al., 2020). For example, Alemi and colleagues (2016) investigated Afghan refugees' understanding of depression symptoms and found that they confirmed experiencing cognitive symptoms (e.g., difficulty concentrating), somatic symptoms (e.g., trouble eating), and cultural conceptualizations of distress (e.g., *ghamgeen* or “sadness”). However, Afghan immigrants face numerous challenges when interacting with a country's public

health system, including delayed preventive care, untreated pre-existing medical conditions, and severe mental distress brought on by prior exposure to chronic stress in their home countries, as found by a researcher in Italy (Reihani et al., 2021). All of these difficulties are layered on top of the difficulties of adjusting to a new society.

The mental health of refugees presents a unique challenge to countries of transition and resettlement, which are tasked with aiding these vulnerable individuals in recovering psychologically from their experiences (Byrow et al., 2020). In general, refugees experience a high rate of psychopathology, making access to mental health care crucial, and there has been an increased demand in recent decades for psychological services for traumatized refugees and asylum seekers (Byrow et al., 2020).

However, refugee services vary considerably in quality, and they are not universally available. Despite the relatively higher economic opportunities and robust health systems in the U.S., it can be challenging to obtain resources that support health during the resettlement process. For example, asylum seekers whose refugee protection claims have not been assessed typically have restricted access to services. In a systematic review of articles on barriers to mental health service use among refugees resettling in the European Union, authors identified three categories of barriers: structural barriers (e.g., lack of services), cultural barriers (e.g., stigma), and refugee-specific factors (e.g., sex, age, education, and years in the new country, lack of social support (Byrow et al., 2020).

According to both qualitative and quantitative studies, mental health stigma is a major cultural barrier refugees face when seeking treatment, and high levels of mental health stigma are associated with reduced help-seeking (Byrow et al., 2020; Satinsky et al., 2019). Findings from qualitative studies suggest that refugee experiences influence both beliefs about mental illness

development and engagement with mental illness treatment. As a result of conflict and persecution, refugees may suffer multiple forms of interpersonal trauma, including rape, torture, attacks, and witnessing the death or injury of a loved one. After these experiences, people often lose trust in others, regardless of reaching safety in the resettlement country (Byrow et al., 2020). Refugees also talk about inadequate mental health services, including the lack of cultural responsiveness of service providers and treatment expenses coupled with a lack of adequate health insurance (Byrow et al., 2020).

Gender and education level of refugees may also play a role in perceived barriers and supports for mental health care. For example, in the U.S., women are more likely to use mental health services than men (Gove, 1984; Kessler et al., 1981; Veroff et al., 1981), and lower mental health care utilization has also been associated with low educational level (Halme et al., 2023; Wang et al., 2007)

Overall, mental health is not recognized as something that needs attention from medical professionals. However, issues of gender and education play a role. For example, in Afghanistan, women experience trauma, abuse, and unfair treatment because of their gender (Neyazi et al., 2023). Research suggests that almost three-quarters of Afghan women are dealing with symptoms of depression, and Afghan women who cannot read or write are much more likely to feel depressed than those who can read and write (Neyazi et al., 2023).

In Afghanistan, mental issues are often interpreted based on the sex of the person experiencing them. Men, who are expected to support their families, might express their frustrations on family members or self-treat their mental health issues with illegal drugs, which were easily accessible. When a woman falls ill, decisions about healthcare are typically made by males, such as the husband for a married woman or the father or brother for an unmarried woman

(Neyazi et al., 2023). If an Afghan woman complains of mental health issues, she might be considered someone who has “lost her mind” or “gone crazy.” Families might take women with mental health complaints or symptoms to a religious figure to rid her of possible black magic or a troublesome djinn. Even educated women might not disclose their mental health issues to their husbands or families, even if they themselves seek services. Additionally, few women have their own money to get help (Neyazi et al., 2023).

Recognition of mental health issues and the acceptance of care also varies by education level. In Afghanistan, many girls were unable to attend school due to insecurity, poverty, displacement, and cultural and government restrictions. For instance, the majority of teachers in rural areas were male, and many families would not allow girl children and adolescents to be taught by a man. According to Human Rights Watch, the education of women was not valued in Afghanistan, and approximately one third of girls are married before they reached the age of 18 (Barr, 2017).

Although men have more freedom, few men in Afghanistan have had the opportunity to receive an education due to war, instability, and displacement and are working to support their families. Consequently, they might not have had time to prioritize their mental health or seek help. Also, because of all the fighting and problems in Afghanistan, it is difficult for people to get the help they need for their mental health (Neyazi et al., 2023).

While earlier studies are enlightening, none included the most recent refugees from Afghanistan, those arriving in the past few years. Additionally, few studies have looked at differences by gender and education level. The purpose of this study was to build on past research to examine in more depth the supports and barriers for Afghan refugees in the U.S.

Methods

Study Design

An interview-based qualitative approach was employed in the study.

Sample

In Fremont, participants were recruited through the Afghan Coalition. In Sacramento, connections were established through a friend to other Afghans living in the area. Most of the participants were associated with one of the Afghan grocery stores, several of which also have bakeries, butchers, and restaurants. A combination of quota sampling and snowball sampling was used, ensuring that I interviewed two to three women who did not attend school or stopped schooling after grades 6, 8, or 12, two-to-three women who attended college, two-to-three men who did not attend school or stopped schooling after grades 6, 8, and 12, and women who attended college.

Research Ethics

This study obtained approval from the University of Hawai'i Institutional Review Board. Participants were informed of the study's purpose and potential risks through the consent form (Appendix B). Both the interview questions and informed consent were translated by an official translator into Dari and Pashto languages to ensure comprehension. Participants were given the option to waive questions, end the interview, or withdraw from the study if any questions caused discomfort or stress.

Participants were also briefed on the confidentiality measures in place for their data. Upon enrollment, each participant received a unique identification number. Information related to the study participants and their identification number was stored on a password-protected computer with demographic information, consent forms, and responses kept separate from

individuals' names. Any reports or publications resulting from the study were presented in summary format without personal identification.

Measures

As part of the interview process, demographic information was collected about the respondent, including age, education, occupation, and when they left Afghanistan and came to the U.S. (Table 3.1). The participants had the option of engaging in the interviews in one of three languages: English, Dari, or Pashto.

Table 3.1. Study 2 Demographics Questions

Questions	Response Options
Are you Afghan?	Yes No
What languages do you speak?	Pashto Dari English Other
What type of work do you do? For example, registered nurse, janitor, cashier, auto mechanic? Are you employed?	1 Employed for wages. 2 Self-employed 3 Out of work for 1 year or more 4 Out of work for less than 1 year 5 A homemaker 6 A student 7 Retired 8 Unable to work
What is the highest level of education you completed?	1 Never attended school or only attended kindergarten. 2 Grades 1 through 8 (Elementary) 3 Grades 9 through 11 (Some high school) 4 Grade 12 (High school graduate) 5 College 1 year to 3 years (Some college or technical school) 6 College 4 years or more (College graduate)
What year did you leave Afghanistan?	
What year did you come to the U.S.?	
May I know how old are you?	Age 18-34

	Age 35-49 Age 50 and above
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During the interview, participants were asked multiple questions about the support and barriers they encounter when trying to access mental health services in the U.S. (Table 3.2).

These questions were guided by the ecological framework shown in Figure 1.2.

Table 3.2. Study 2 Interview Questions and Measures

Level	Category	Study 2
Individual	Introduction	How are you?
Individual	Experience	Please tell me your experience emigrating from Afghanistan.
Individual	Needs	What individual needs do you have?
Interpersonal	Needs	What interpersonal needs do you have?
Societal	Needs	What societal needs do you have?
Individual	Needs	Do you feel happy?
All	Needs	What is preventing you from feeling happy?
Societal	Culture	How does culture play a role in receiving mental health services?
All	Access	What mental health services are available for you?
All	Access	What barriers are preventing you from accessing mental health care?
All	Assessment	How do you decide when to see a mental health service provider?
All	Treatment	What treatment plans were recommended for you?
All	Treatment	What barriers are preventing you from following the treatment plan?
All	Conclusion	Please share an example of how you overcame a barrier in mental health access, assessment, or treatment.

Procedures

After the informed consent procedure, the interviews were conducted face-to-face at venues considered safe to the participants. Each interview lasted for about one hour. With the participants' consent, interviews were audio recorded. As a token of appreciation for their

participation, women received a locally made tote bag valued at \$15, while men received a locally made hat valued at \$8.

Analysis Plan

The interview transcripts were transcribed and written onto a Word document in preparation for coding and analysis. Transcription view included identifying emerging issues related to the perception of Afghan refugees' mental health needs and the obstacles they face. I utilized an Excel spreadsheet to manage the codes and themes effectively. Dr. Kathryn Braun, the chair of this dissertation committee, assisted in confirming the codes and themes.

Results

Characteristics of the Sample

Twenty Afghan refugees were interviewed; 12 interviews were conducted in Fremont and eight in Sacramento. Among participants, 5 were college-educated men, 5 were college-educated women, 5 were men who stopped their education at or before the 12th grade, and 5 were women who either never attended school or stopped at or before the 12th grade. The average age of those interviewed was 35 years, with a range from 35 years to 70 years. Of these, seven arrived in the U.S. since U.S. withdrawal and takeover by the Taliban. Of these, 3 were college-educated men, but only one had good English-language skills, and four were women, two college educated and two not, but only two spoke rudimentary English. Although a few noted immigration-related struggles, out of 20, 11 had green cards, five had U.S. passports, and four were pursuing asylum.

Barriers

From the interviews with 20 individuals, seven themes were identified: 1) distress related to trauma experienced in Afghanistan and separation from family; 2) financial constraint coupled with lack of employment, career, and educational opportunities; 3) difficulties balancing work

and family responsibilities, including support for family still in Afghanistan; 4) difficulties with cultural adjustment, integration, and acceptance; 5) language barriers and dependence for others; 6) cultural stigma around mental health; and 7) limited access to health care, mental health care, and social services.

Barrier 1: Distress from Afghanistan and separation from family

All 20 individuals spoke to this theme. Regardless of when respondents came to the U.S., they still expressed some level of distress resulting from their experience in Afghanistan and as a refugee. There were a number of reasons for this distress, including trauma from war, the profound feeling of separation from beloved family members, and the challenging environment in which they found themselves. For example, an uneducated woman from Sacramento said, “The fact that we left our home country and became immigrants is preventing me from feeling happy. Being away from my mom, my siblings, is very difficult for me.” Another woman with low education recounted her experience coming to the US in the 1980s, saying.

My family left Afghanistan...and he died in Pakistan. When I got to the U.S., I had to do everything. I only had \$850 and owed money to some people, and I didn't have access to my husband's retirement money in Afghanistan. So, I had to rent a place and find a job and get my children in school. It was hard.

Although all groups expressed distress related to their experiences, educated individuals expressed their feelings with more nuance and detail, often discussing the psychological impact of trauma and separation from family members in greater depth than those who were uneducated.

Separation and war trauma are deeply ingrained. As expressed by a college-educated man in Fremont, “The memories of Afghanistan are like scars that never fade. Being separated from my family feels like a wound that never heals. It's a constant battle to stay strong.” A man with

low education in Fremont said, “The trauma of war and the separation from my family are like heavy clouds that hang over me. It’s hard to find peace when so much pain weighs on my mind.” College-educated women in Fremont echoed these sentiments, with one sharing, “Every night, I can’t help but think about the loved ones I left behind in Afghanistan. The trauma of war still haunts me, and the distance from my family only adds to the pain.” Another woman said, “The pain of leaving my homeland and my family behind is something I carry with me every day. It’s a weight on my heart that never seems to lessen, no matter how much time passes.”

Barrier 2: Financial constraints, lack of employment and educational opportunities

Nineteen of the 20 individuals spoke on this theme. Financial struggles were discussed by both educated and uneducated individuals, but educated individuals often talked about these challenges in the context of their dreams of advancing their careers or pursuing higher education, whereas uneducated individuals focused primarily on surviving on a day-to-day basis. For example, a woman with low education from Sacramento saying, “My individual needs are food, driver’s license, and learning the language. When we came first, we didn’t even have a pillow.” A college-educated woman from Sacramento said, “The rent of the house is around \$2,500 to \$3,400. It is too much for me. I am a single mom. My son was born here. I can’t afford to raise my son or pay for his expenses.”

Women and men with educational backgrounds expressed frustrations with the job market in Fremont despite their qualifications. One educated man lamented, “Despite my qualifications, finding a job that pays enough to support my family has been a constant struggle. The financial stress is overwhelming, and it feels like there’s no way out.” Similarly, an educated woman shared, “Even with my education, the job market is tough. It’s a constant battle to find employment that matches my skills and provides financial stability for my family.”

Uneducated individuals in Fremont, on the other hand, highlighted the dire consequences of a lack of formal education on their employment prospects. “Without education, it’s nearly impossible to find decent work that pays enough to make ends meet. We’re stuck in a cycle of poverty with no way to break free,” expressed one uneducated man. A woman who is uneducated also said, “Without proper education, finding a job that pays enough to support my family is like chasing a dream. We’re always struggling to make ends meet.”

Educated individuals in Sacramento faced similar challenges in the job market as those in Fremont. “Even with my education, the job market is tough. It’s a constant battle to find employment that matches my skills and provides financial stability for my family,” shared an educated man. Similarly, an educated woman commented, “Despite my qualifications, finding a job that pays enough to support my family has been a constant struggle. The financial stress is overwhelming, and it feels like there’s no way out.”

Barrier 3: Balancing work and family responsibilities in U.S. and Afghanistan

Twelve of the 20 individuals spoke to this theme. The gendered division of labor within families was emphasized by educated individuals, particularly women, who often talked about the difficulties managing household tasks while pursuing education or employment opportunities. For example, a woman with low education from Sacramento said, “Since I am the only one working, and the breadwinner of the family, I have to take care of everything financially. I can’t afford to send them [family still in Afghanistan] money.”

The challenge of balancing work commitments and providing for their families in Afghanistan was daunting for educated women and men in Fremont. One educated man expressed the challenges, stating, “Juggling work responsibilities with supporting my family back in Afghanistan is a constant challenge. There are days when I feel like I’m being pulled in

every direction, trying to meet everyone's needs." Similarly, an educated woman shared her experience, saying, "Supporting my family in Afghanistan while trying to excel in my career here is no easy feat. It's a delicate balance that requires constant effort and sacrifice."

Uneducated individuals in Fremont also expressed difficulties. One man said, "I'm the sole breadwinner for my family here and back home. Balancing work commitments while providing financial support to my loved ones in Afghanistan is a heavy burden to bear." Echoing this sentiment, an uneducated woman highlighted, "Juggling work responsibilities with supporting my family back in Afghanistan is a constant struggle. There's never enough time or resources to meet everyone's needs."

Barrier 4: Cultural adjustment, integration, and acceptance

All 20 individuals spoke to this theme. There were no significant differences between discussions of cultural adjustment based on education or gender. Individuals with and without education reported difficulties adapting to American culture, feeling accepted, and navigating cultural differences. For example, a woman with low education from Fremont felt belittled by physicians because of she wears a head scarf, saying, "I needed to go to the emergency room yesterday. Since I wore a scarf, the doctors at the emergency misbehaved with me."

As educated women and men adjusted to their new surroundings in Fremont, they face cultural challenges, integration challenges, and acceptance challenges. One educated man reflected on his experience, stating, "Adjusting to a new culture and trying to fit in has been challenging. It's like navigating through unfamiliar territory every day, trying to find my place in this new society." Similarly, an educated woman shared her journey, saying, "Being accepted in a new culture while holding onto my own identity has been a journey filled with ups and downs. It's not easy to find a balance between embracing new traditions and honoring my roots."

Similarly, uneducated individuals in Fremont face a daunting task integrating into American society while maintaining their Afghan identity. “The cultural differences between Afghanistan and the US are vast. Integrating into American society and being accepted for who we are is a constant struggle,” expressed one uneducated man. A woman who is uneducated added, “Cultural integration is like walking a tightrope. We’re torn between holding onto our Afghan identity and trying to blend in with American society. It’s a delicate dance that requires careful navigation.”

The experiences of educated women and men in Sacramento regarding cultural adjustment and acceptance are similar. An educated man described his journey, stating, “Adapting to a new culture while preserving my own identity has been a journey filled with challenges. Finding acceptance in a society that’s so different from my own is an ongoing struggle.” One educated woman said, “Adjusting to a new culture and trying to integrate into society has been a rollercoaster ride. There are days when I feel like I belong, and others when I feel like a stranger in my own skin.”

A similar challenge is faced by uneducated individuals in Sacramento when it comes to cultural integration and acceptance. “The process of cultural adjustment is like swimming against the current. We’re constantly struggling to find our place in a society that’s so different from what we’re used to,” voiced one uneducated man. Reflecting this sentiment, an uneducated woman emphasized, “Cultural integration is like trying to fit a square peg into a round hole. We’re constantly battling to find acceptance in a society that’s unfamiliar and sometimes unwelcoming.”

Barrier 5: Language barriers and dependence for others

Fourteen of the 20 individuals spoke on this theme. For example, a woman with low education from Fremont said, “We need to rely on our children to translate for us because we cannot speak English fluently.” An educated woman from Sacramento said, “The main barrier for me at that time was the language that I could not speak fluently and there were no clinicians speaking my language.” A man with low education from Sacramento was worried that his children may have to go to another state to find good-paying work, which will leave him alone and without help with navigating life in the English language. He said, “The only thing that is preventing me from feeling happy is that my kids may get jobs in another state, as is happening to others, and I will be left alone.”

People with higher levels of education, particularly men, were more likely to seek out language-learning opportunities or use translation services to overcome these barriers. Still, a college-educated man in Fremont reported, “Language barriers make everyday tasks feel like monumental challenges. We’re constantly reliant on others for translation and communication, which can be frustrating.” Similarly, an educated woman shared her sentiments, stating, “Not being able to speak the language fluently makes us feel isolated and dependent on others for even the simplest of tasks. It’s a constant reminder of our limitations in this new country.”

Additionally, language barriers increase feelings of dependency and disempowerment among the uneducated in Fremont. “Without proficiency in the language, we’re forced to rely on others for basic needs like medical appointments or grocery shopping. It’s a daily struggle that reminds us of our dependence on others,” expressed one uneducated man. In agreement, an uneducated woman stated, “Language barriers make it difficult to navigate everyday life. We’re constantly dependent on others for translation, which can be disempowering.”

Educated Afghan refugees in Sacramento face similar challenges due to language barriers that impact their sense of belonging and opportunities. “Language barriers create barriers to opportunities. We’re often at the mercy of others for translation, which can be disempowering. It’s a constant struggle to overcome these linguistic hurdles,” reflected an educated man in Sacramento. Similarly, an educated woman expressed, “Not being able to speak the language fluently makes us feel like outsiders. We’re constantly dependent on others for translation and communication, which can be frustrating and isolating.”

Similar barriers hinder uneducated individuals in Sacramento from communicating and navigating daily life effectively due to language barriers. “Language barriers make it hard to communicate and navigate daily life. We’re often reliant on others for translation, which can make us feel disempowered,” voiced one uneducated man. A woman who lacked education emphasized, “Without proficiency in the language, we’re constantly dependent on others for even the simplest tasks. It’s a constant reminder of our limitations and can be quite frustrating.”

Barrier 6: Cultural stigma around mental health

Thirteen of the 20 individuals spoke about this theme. For example, a woman with low education from Sacramento said, “Culture plays a big role in receiving mental health services. When one was going to get mental health services [in Afghanistan], they were called crazy, *diwana*. But here if one is depressed, they can visit a doctor.” Another woman with low education said, “Our culture is rich, but there are people who misuse it. They banned girls from going to school, which is not in our culture. Our culture’s current condition is affecting our mental health as well.” An educated man stated, “In Afghan culture, there’s a stigma attached to mental health issues. Seeking help for psychological struggles is often seen as a sign of weakness rather than strength, which can prevent people from getting the support they need.” Similarly, an

educated woman shared, “Mental health problems are often brushed under the rug in Afghan communities. There’s a fear of being judged or ostracized if one admits to struggling with psychological issues, so many suffer in silence.”

Due to cultural norms, mental health issues are taboo and often kept private among the uneducated in Fremont. One uneducated man emphasized, “In Afghan culture, mental health issues are often seen as a taboo topic. There’s a reluctance to acknowledge psychological struggles, which can lead to individuals suffering in silence rather than seeking help.” Likewise, an uneducated woman stated, “Cultural norms dictate that we should hide our mental health struggles and put on a brave face. It’s a stigma that prevents many from seeking the help they desperately need.”

In Sacramento, Afghan refugees who are educated face similar challenges, as the cultural stigma around mental health makes it difficult for them to seek support. “The cultural stigma surrounding mental health makes it difficult for individuals to seek help when they’re struggling emotionally. There’s a sense of shame attached to admitting weakness, which can prevent people from getting the support they need,” expressed an educated man. Similarly, an educated woman highlighted, “In Afghan culture, there’s often a belief that mental health issues should be kept private. Seeking help is seen as a sign of weakness, which can prevent individuals from getting the support they need.”

Barrier 7: Limited access to health care, mental health care, and social services

All 20 individuals spoke on this theme. For example, an uneducated woman from Fremont said, “Yes, there are mental health services, but the waiting time is so long. One has to wait for six months to get an appointment.” Although access to healthcare services was challenging for both educated and uneducated individuals, educated individuals, particularly

men, sought out resources and advocated for themselves and their families more actively than uneducated individuals, who often relied on informal networks or community support because they were unaware of the available services.

According to an educated woman from Sacramento, “The lack of access to mental health services is concerning. Even when appointments are available, the language barrier makes it difficult to communicate effectively with healthcare providers.” Additionally, an educated woman from Fremont highlighted, “While there are mental health services in the area, the cost can be prohibitive for many refugees, especially those without insurance. It’s a barrier that prevents us from seeking the help we need.”

A woman from Sacramento who is uneducated expressed, “Accessing mental health care is a real challenge for us. Many of us don’t even know where to start looking for help, and the stigma surrounding mental health in our community only makes it harder to seek support.” Similarly, an uneducated woman from Fremont shared, “I’ve been struggling to navigate the system to access healthcare and educational resources for my family. It’s been challenging without proper guidance and support.”

Supports

From discussions around supports, four themes were identified: 1) individual coping strategies, like mindfulness and faith; 2) education and opportunities for career advancement; 3) social interactions, family support, community support; and 4) services when you can get them, for example support for housing, driving license, health care, education, work, and so forth.

Support 1: Individual coping strategies, like mindfulness and faith

Twelve of the 20 individuals spoke on this theme. A man with low education in Fremont said, “I try to practice mindfulness every day to keep my mind calm and focused.” An educated

man in Fremont revealed, “Mindfulness has been my anchor during turbulent times. It helps me find clarity and inner peace amidst life’s challenges.” An educated woman in Sacramento emphasized the importance of mindfulness, saying, “Practicing mindfulness has been a game-changer for me. It allows me to stay present and centered, even during the toughest moments.”

Most also said they derived strength and resilience from their religious beliefs. For example, a college-educated woman in Sacramento said, “Prayer helps me stay grounded and gives me hope for the future.” A man with low education in Sacramento said, “Whenever I feel overwhelmed, I turn to prayer. It helps me find peace and strength to face challenges.” An uneducated man from Fremont expressed, “Faith is my rock when everything else feels uncertain. It gives me strength and hope to face whatever comes my way.” An uneducated woman from Fremont emphasized the role of faith in her life, asserting, “My faith is my source of strength and resilience. It helps me find peace and solace in times of distress.”

Support 2: Education and opportunities for career advancement

All 20 individuals spoke on this theme. There was a strong emphasis on the importance of education for securing better job opportunities and advancing in their careers. Through vocational training or higher education, they highlighted their efforts to improve their skills. For example, a woman with low education in Sacramento was proud to related. “I am studying IT to improve my job prospects and provide for my family.” A college-educated man from Fremont said, “Education is the key to a better future. I’m working hard to earn my degree and build a successful career”.

According to a man from Fremont who is educated, “Education opened doors I never thought possible. It’s not just about a degree; it’s about unlocking opportunities for career growth and personal development.” An uneducated man from the same area added, “Without education,

it feels like hitting a dead end at every turn. The lack of opportunities for career advancement is a constant reminder of the importance of learning and skill-building.”

Similarly, in Sacramento, an educated woman emphasized, “Investing in education is investing in our future. It’s the key to unlocking doors to better career prospects and a brighter tomorrow.” On the other hand, an uneducated woman expressed concerns about limited career prospects, saying, “The lack of education limits our chances for career advancement. It feels like we’re stuck in a cycle of missed opportunities and unfulfilled potential.”

Support 3: Social interactions, family support, community support

The importance of social interactions, family support, and community support was highlighted by 19 of the 20 respondents. This support was cited as a key source of strength and resilience. For example, a college-educated woman in Fremont said, “My family has been my rock throughout this journey. We support each other and lean on each other for strength.” A man with low education in Sacramento said, “My community has been incredibly supportive, helping me navigate the challenges of resettlement.”

An educated man in Fremont shared, “Having a supportive community and strong family ties has been crucial in navigating the challenges of living in a new country. It’s comforting to know that there are people who have your back no matter what.” In a similar way, an uneducated man in Fremont emphasized the importance of community, stating, “The sense of community here is like a lifeline. Without the support of friends and family, it would be much harder to overcome the obstacles we face as refugees.”

The value of building connections within the community was echoed by an educated woman in Sacramento who stated, “Building connections within the community has been essential for me. Having a support system of friends and family makes the transition to a new

place much smoother.” An uneducated woman agreed, emphasizing the importance of family and community support, “The support of my family and the community has been invaluable. Knowing that there are people who care about us and are willing to help makes all the difference.”

Services

In sixteen of the 20 interviews, individuals mentioned the importance of receiving assistance in accessing essential services, such as housing assistance, healthcare, education, and employment assistance. Generally, those who arrived with the fourth wave of refugees had better access to services than those who arrived earlier, and all the quotes are from this group. For example, a woman with low education in Fremont said, “Obtaining my driving license was a game-changer. It gave me the independence to access healthcare and employment opportunities.” A college-educated woman in Sacramento said, “Securing stable housing and obtaining my driver’s license were crucial steps in establishing myself here. It provided a sense of stability and independence.” A college-educated man in Sacramento said, “The support for housing was a lifeline for my family. We wouldn’t have been able to afford a place to live without it.” A man with low education from Sacramento said: “I have a small family. The case workers helped us a lot, and I got a job right away. Compared to the new arrivals, I did not face problems.” Another man with low education from Sacramento said, “There are mental health services available. At the beginning when I came, I visited the mental health specialist, and I was prescribed medicine. So, I am good now.”

Refugees who arrived in earlier waves mentioned that they were not provided with the same level of assistance. In Fremont, a woman with little education who has lived here for 30

years said, “When I first arrived, mental health services were not as accessible. It was challenging to find the support I needed, and I often struggled alone.”

However, those who came earlier were proud of their ability to obtain housing and employment, to stabilize their lives, and to send their children to college without a lot of support. For example, a man with low education from Fremont said, “When I first came here, mental health services were not widely available. We had to rely on ourselves and our community for support during tough times.” A college-educated woman who came in 40 years ago and now works with refugees, said, “I try to tell them, don’t get too dependent on us because at some point you have to rely on yourselves to integrate and survive in the U.S.”

“Accessing mental health services was a turning point for me,” expressed an educated man in Fremont. “It allowed me to address my mental health concerns and work towards healing and recovery.” According to an uneducated man from Fremont, “When I first sought help from mental health services, it was like a weight lifted off my shoulders. Having someone to talk to and support me through difficult times made a big difference.” One educated woman who moved to Sacramento shared her perspective: “Mental health services provided me with the tools and support I needed to cope with anxiety and depression. It’s reassuring to know that help is available when I need it.” According to an uneducated woman from Sacramento, “I was hesitant to seek help for my mental health at first, but accessing mental health services changed my life. It’s important for others to know that there’s support out there.”

Discussion

The findings presented in these studies are consistent with existing literature about Afghan refugee mental health challenges. A lack of culturally competent services and financial limitations are among the structural barriers preventing refugees from accessing healthcare

(Neyazi et al., 2023). The findings also are consistent with prior research that identifies significant obstacles that refugees face when navigating healthcare systems, particularly in unfamiliar environments (Byrow et al., 2020). Moreover, the depiction of mental health stigma within Afghan culture corroborates findings from previous research. Refugees are reluctant to seek help for mental health due to a pervasive fear of judgement and cultural misconceptions (Byrow et al., 2020; Neyazi et al., 2023). Byrow et al. (2020; 2023) emphasize the substantial impact of stigma on refugee populations' help-seeking behaviors.

There are aspects of the interviews that differ from existing literature, including the importance of community support and resilience in overcoming barriers to mental health services. Although stigma is widely believed to discourage refugees from seeking mental health services, the narratives suggest that refugees are willing to seek assistance when needed. (Byrow et al., 2020) and Satinsky et al., (2019) argue that this discrepancy challenges traditional understandings of stigma as a pervasive barrier.

Furthermore, the experiences of educated refugees depicted in this study may not fully reflect the diversity of challenges refugee populations face, and Neyazi et al., (2023) called for further investigation of these nuances in future studies of refugees (Neyazi et al., 2023). There may also be other factors influencing refugee mental health access (Halme et al., 2023).

In addition to shedding light on specific barriers and coping mechanisms that are not well documented in previous literature, the case histories shed light on the experiences of educated Afghan refugees in accessing mental health services. As an example, the narratives describe the practical challenges refugees face during resettlement because of a lack of transportation and a lack of language skills. Additionally, the narratives demonstrate how education and employment

aspirations shape refugees' perceptions of well-being and resilience, offering novel insights into the interplay between socioeconomic factors and mental health.

Strengths and Limitations of the Study

Among the study's strengths was its qualitative approach, which allowed for in-depth exploration of individual experiences and perspectives among educated Afghan refugees. Diverse case studies from women and men refugees in Sacramento enhanced the study's comprehensiveness and provide a broader understanding of refugees' challenges and strengths. The study offers valuable insights into developing culturally relevant and tailored interventions for refugee mental health by exploring the intersectionality of barriers and coping strategies.

As the sample size of case stories is relatively small, findings may not be generalizable to the broader population of Afghan refugees. As a qualitative study, data interpretation may be subject to bias or subjectivity, emphasizing the need for triangulation with quantitative methods in future studies.

Recommendations for Practice

This study recommends developing culturally competent mental health services tailored to the needs and preferences of Afghan refugees. A key focus area for policymakers and service providers should be eliminating structural barriers to refugees' access to care, such as transportation limitations and language barriers. Reducing mental health stigma and promoting help-seeking behavior among refugees can be achieved through community-based interventions that leverage existing social networks and cultural norms. It is important to emphasize that multi-sectoral approaches to refugee integration and well-being emphasize the importance of enhancing educational and employment opportunities for refugees.

Chapter 4. The Influence of Gender, Socioeconomic Status and Years in the U.S. on Mental Health Service Use among Afghan Refugees in the U.S.: A Quantitative Study

Introduction

Refugees' mental health is influenced by many factors, including socioeconomic status, sex, and years in the U.S. (Hynie, 2018). In the area of socioeconomic status, refugees often cope with unemployment and underemployment, which can negatively affect health. For example, a study in Guangzhou, China, found that factors such as occupation, gender, and years of employment can affect the psychological well-being of migrant workers. Specifically, Guan found that financial difficulties, job difficulties, and marital status significantly affected migrant workers' mental health, and they found worse mental health status among temporary employment than among stable employees (Guan, 2017).

Among refugees, downward social mobility is a risk factor for poor health, as this experience may be associated with perceived social devaluation. As a result, anxiety and depression may occur as a result of feeling out of control in different spheres of life (Costa et al., 2020). Wanner and his colleagues discovered that well-educated Ghanaian migrants in Germany experienced a personal devaluation when their qualifications are not accepted and they take on jobs with relatively low value. A number of other studies have found high rates of education-occupation mismatches between immigrants and native-born individuals Europe (Wanner et al., 2021).

The labor market outcomes of immigrants are crucial indicators of their success and integration. A significant issue is the mismatch between their skills, qualifications, and jobs. Examples include highly skilled professionals working in low-skilled jobs, such as Romanian

engineers working as cleaners. In Europe, 22% of immigrants are overeducated compared to 13% of natives, with rates reaching 35% in Great Britain and 47% in Portugal. This overqualification not only represents wasted potential but also leads to persistent wage penalties, exacerbating inequalities between immigrants and native-born workers (Aleksynska & Tritah, 2013)

An analysis of the data from the study by Allen (2001) shows that educational mismatches are widespread. Specifically, 14% of higher vocational education graduates and 8% of university graduates felt overqualified for their jobs. About one-third of both groups believed a lower level of education would suffice for their roles. Additionally, roughly 20% were employed in positions not suited to their field of study. Overall, about half of university graduates and 56% of higher vocational education graduates were in jobs mismatched to their education level or field (Allen, 2001).

Additionally, the conditions of travel, arrival, and resettlement could impose an “averaging” effect on perceived socioeconomic position among refugee (Costa et al., 2020). As an example, several European countries receive refugees in dedicated collective accommodations and have equal processing requirements for issuing documentation, provide the same basic monthly monetary stipends, provide the same information about basic rights, and arrange relocation schemes according to pre-established policies (Costa et al., 2020).

Mental health symptoms and service use also are influenced by sex. For example, in the U.S., women are more likely to use mental health services than men. Notably, 11.3% of women, compared to only 6.6% of men, have contacted mental health services at some point in their lives.(Gove, 1984; Kessler et al., 1981; Veroff et al., 1981). Afghan women, however, may not use more mental health services, especially if they are uneducated. In Afghan culture, women

often require permission from their husbands or fathers to engage in with health care providers, a tradition that may persist after resettlement (Gove, 1984; Kessler et al., 1981; Veroff et al., 1981).

Spending more years in the U.S. tends to result in greater awareness of mental health needs and increased use of services. For example, the literature suggests that newly arrived immigrants are less likely to utilize mental health services compared to individuals who have lived in the U.S. longer (Saasa et al., 2021). In order to seek mental health care, individuals need to perceive mental health needs, as well as be evaluated by healthcare professionals.

The longer someone has lived in the U.S., the more likely they are to become aware of their mental health needs and to access mental health services (Saasa et al., 2021). Research also indicates that the longer immigrants live in the U.S., the more they tend to acculturate. This acculturation process includes adopting the cultural norms of the host country, such as becoming more aware of and developing positive attitudes towards mental health services. For example, Derr (2016) found that immigrants with extended residence in the U.S. are more likely to use mental health services because they are more familiar with the healthcare system and face less stigma related to mental health issues (Derr, 2016).

No studies of the influence of socioeconomic status, sex, and years in the U.S. was found among Afghan refugees in the U.S. Thus, the purpose of this study is to survey a relatively large number of Afghan refugees in the U.S. to see if their use of mental health services is associated with socioeconomic status, sex, and years in the U.S.

Methods

Study Design

A cross-sectional survey was conducted among Afghan refugees residing in Sacramento and Fremont California who entered the U.S. anytime the past 40 years.

Sample

To qualify for this study, individuals needed to have left Afghanistan involuntarily and arrived in the U.S. as refugees, asylum seekers, or under another legal status and were currently residing in California. Clients affiliated with refugee organizations were approached and requested to participate. They could either complete the survey in person on the researcher's laptop or by themselves online following a secure link to the survey. The survey was available in three languages, and participants could choose to complete it in Dari Pashto, or English.

Research Ethics

The project received approval from the Institutional Review Board (IRB) at the University of Hawai'i. Informed consent was obtained at the beginning of the survey, and participants were informed of potential risks through the consent form. They also were informed that they had the option to skip the question or end the online survey at any time. Participant information was collected anonymously, and no identifying information was requested. However, respondents were asked to answer three screening questions to determine their eligibility to participate in the survey, and they are described below.

Measures

The survey consisted of 41 items divided into six categories. The first category, verification, contained three items to confirm that the participant qualified for the survey, including: 1) Are you an Afghan refugee, asylum seeker or Special Immigrant Visa (SIV) case holder.? (yes/no); 2). Are you living in California? and 3) Are you 18 or older? (yes/no).

Demographics. The second category, demographics, included 12 items related to gender (male, female, or other), marital status (married or not married), education level (high school or less, some college or graduated college, or graduate education), number of people living in the

home, current employment status (yes or no), and income, and employment (yes or no), and income in Afghanistan. This section also included items for which response categories were collapsed, such as feelings of safety (safe, unsafe, or unsure) and integration in the community (integrated, not integrated, or unsure).

Health. The third category, health, contained four items, many of which were collapsed as noted, including self-rated health (good, very good, or excellent vs. fair or poor), comfort speaking in English to your doctor (comfortable or uncomfortable), comfort understanding written information from your doctor (easy or difficult), and health insurance (yes or no).

The fourth category consisted of one item asking them to check all the issues encountered during resettlement, including: 1) Cannot afford to live in the US; 2) Cultural conflicts within family; 3) Difficulty adjusting to new situations in US; 4) Difficulty learning new things in US; 5) Difficulty raising children in US; 6) Discrimination; 7) Documentation problems; 8) Driver's license issues; 9) Feeling US is not your country; 10) Missing friends and family in Afghanistan; 11) No vacation time or sick leave; 12) Not having health insurance or being underinsured; 13) Trouble at work; 14) Unemployment; 15) Worried or sentimental about life back in Afghanistan; 14 Other. This was developed based on literature.

The fifth category focused on feelings experienced within the past two weeks, for example crying, feeling sad, having difficulties falling asleep, arguing with family members, feeling hopeless, feeling isolated, having bad memories. These were post-coded as everyday vs. 1-5 times a week. These items were drawn from the 22-item Afghan Symptom Checklist (ASCL) by Miller et al. (2016).

The sixth category, social support, included eight items related to feelings of general support they felt by their family, friends, culture, and community (collapsed into supported vs.

not supported), as well as feelings of support when feeling sad, anxious, or stressed. Four more questions asked about feelings of stigma from family, friends, culture, and community expressing sadness, stress, or anxiety (yes/no). This items was developed from literature.

The final category, service use, comprised five items asking about knowledge, use, and access to mental health services in Afghanistan (yes/no) and in the U.S. (yes/no). Those that wanted services and could not get them were asked about barriers, and those that received services were then asked about frequency, types of mental health services provider, and ease of access. The survey was administered using Google Forms, and both the survey items and informed consent were translated from English to Pashto and Dari.

Analysis

R was employed to analyze the data. Descriptive statistics were run to characterize the sample. Chi-square tests were conducted to assess differences in the usage of mental health services among refugees with higher education, income, or years living in the U.S., as well as gender. P-values, with a cut-off of 0.05, indicate the significant level of each characteristic's association with mental health care use.

Logistic regression was employed to assess the strength of association between various factors and the utilization of mental health services in the U.S., with “did you use mental health services in the U.S.?” serving as the dependent variable. The analysis included the variables sex, socioeconomic status, years lived in the U.S., and others. Significant associations were identified and are reported with their respective relative strengths where appropriate.

Results

Sample

In all, 187 individuals opened the survey. Of these, 29 were ineligible to participate because they either they were not an Afghan refugee, asylum seeker or Special Immigrant Visa case holder, were not living in California, or were not 18 or older. Thus, the analytic sample included 158 individuals. About half 75 (47.5%) completed the survey in Dari, 60 (38.0%) in English, and 24 (14.6%) in Pashto.

Bivariate Analysis

Characteristics of the analytic sample and the subsamples using and not using mental health services in the U.S. are shown in Table 4.1. Of the total sample of 158 individuals, 51 (32.3%) reported having used mental health services, and 107 (67.7%) reported not having use or unsure if they used mental health services. A greater proportion of those having used mental health series in the U.S. were female (64.7%), compared to male (35.3%), and this difference was statistically significant ($p=0.026$). About 74% of the sample was married, and 44.3% of the sample had a high school education or less, and there was no difference in these variables for those using and those not using mental health services in the U.S. Nor did the number of dependents exhibit a statistically significant association with mental health service use.

Employment status did not differ by service use in Afghanistan or the U.S, nor did estimated household income in Afghanistan. However, household income in the U.S. demonstrated a statistically significant association with mental health service utilization ($p=0.014$), with individuals with household incomes below 28,000USD more likely to use mental health services compared to those with higher incomes. Interestingly, about 57% of the sample did not answer the question about the year they arrived in the U.S., and this percentage was similar for those the used and did not use services. Of those who provided data, all but four

arrived since 2001 and, of these, 26 arrived with the withdrawal of the U.S. (since 2020). There was no difference in year of arrival between those that used and did not use services.

Table 4.1. Bivariate Analysis: Demographic Variables and Mental Health Use in the U.S.

	Total sample (n= 158)	Did not use MH services in U.S. (n=107)	Used MH services in U.S. (n= 51)	p-value
Language				0.242
Dari	75 (47.5%)	48 (44.9%)	27 (52.9%)	
English	60 (38.0%)	40 (37.4%)	20 (39.2%)	
Pashto	23 (14.6%)	19 (17.8%)	4 (7.8%)	
Sex				0.026
Female	82 (51.9%)	49 (45.8%)	33 (64.7%)	
Male	76 (48.1%)	58 (54.2%)	18 (35.3%)	
Married	116 (73.9%)	82 (77.4%)	34 (66.7%)	0.153
Number of dependents	3.2 ± 2.6	3.5 ± 2.7	2.7 ± 2.3	0.083
Education level				0.721
Graduated high school or less	70 (44.3%)	49 (45.8%)	21 (41.2%)	
Some or graduated college	61 (38.6%)	39 (36.4%)	22 (43.1%)	
Master or PhD degree	27 (17.1%)	19 (17.8%)	8 (15.7%)	
Employed in Afghanistan?	103 (65.2%)	71 (66.4%)	32 (62.7%)	0.656
Monthly household income in Afghanistan				0.272
Less than 12,000AFN (\$169.53)	28 (17.7%)	15 (14.0%)	13 (25.5%)	
12,001AFN to 40,000AFN (\$169.55 to \$565.10)	71 (44.9%)	50 (46.7%)	21 (41.2%)	
More than 40,000AFN (\$565.12)	49 (31.0%)	36 (33.6%)	13 (25.5%)	
Unknown	10 (6.3%)	6 (5.6%)	4 (7.8%)	
Employed in the U.S.	99 (62.7%)	71 (66.4%)	28 (54.9%)	0.164
Annual household income in U.S.				0.014
Less than 28,000USD	82 (55.0%)	47 (47.0%)	35 (71.4%)	
28,001USD to 55,000USD	31 (20.8%)	26 (26.0%)	5 (10.2%)	
More than 55,000USD	36 (24.2%)	27 (27.0%)	9 (18.4%)	
Year of arrival in U.S.				0.799
Before 9/11	4	2	2	
After 9/11 to 2019	26	17	9	
With U.S. withdrawal 2020-present	38	26	12	

Missing data	90 (56.9%)	62 (57.9%)	28 (54.9%)
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Responses to questions about safety and stigma and mental health service use are shown in Table 4.2. A borderline significant association was observed between individuals' sense of safety within their U.S. community and mental health service utilization ($p=0.058$), as individuals feeling safe being more inclined to use mental health care. A statistically significant association was also observed between the degree of integration in the U.S. community and use of mental health services ($p=0.034$), with those feeling very integrated more likely to use services. Only a third of the sample answered the questions about feeling stigmatized by others when they expressed sadness, stress, or anxiety. Among those that answered, more individuals using mental health services said they felt stigmatized by family and friends than those that did not use services ($p=0.026$ and $p=0.036$, respectively).

Among the respondents, about 43.5% reported being bothered by resettlement-related issues in the past month (Table 4.2). The issues most often reported were missing friends/family in Afghanistan (66.7%), feeling worried or sentimental about life back in Afghanistan (41.8%), and having difficulty adjusting to new situations in the U.S. (43.5%). Only a few resettlement-related issues were significantly associated with use of mental health services. Larger proportions of individuals who reported difficulty adjusting to new situations, difficulty learning new things in the U.S., discrimination and documentation problems had not used mental health services, suggesting that perhaps interfacing with mental health providers was helping those that used services to better cope with life in the U.S.

Table 4.2. Bivariate Analysis: Safety and Stigma Variables and Mental Health Use

	Total sample (n=158)	Did not use MH services in U.S. (n=107)	Used MH services in U.S. (n= 51)	p-value
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Feeling safe in your U.S. community				0.05822
Safe	133 (84.2%)	86 (80.4%)	47 (92.2%)	
Neither/Unsafe	25 (15.8%)	21 (19.6%)	4 (7.8%)	
Safe	133 (84.2%)	86 (80.4%)	47 (92.2%)	
Feeling integrated in your U.S. community				0.034
Very integrated	44 (28.2%)	24 (22.6%)	20 (40.0%)	
Integrated	87 (55.8%)	61 (57.5%)	26 (52.0%)	
Neither/Unintegrated	25 (16.0%)	21 (19.8%)	4 (8.0%)	
Feels stigmatized when expressing sadness, stress, or anxiety by:				
Family	46 (29.5%)	25 (23.8%)	21 (41.2%)	0.026
Friends	47 (30.1%)	26 (24.8%)	21 (41.2%)	0.036
Community	46 (29.3%)	28 (26.4%)	18 (35.3%)	0.252
Resettlement-related issues in the past few months				
Cannot afford to live in the U.S.	13 (9.7%)	9 (9.9%)	4 (9.3%)	>0.999
Cultural conflicts with family	29 (21.0%)	22 (23.4%)	7 (15.9%)	0.314
Difficulty adjusting to new situations	60 (43.5%)	47 (50.0%)	13 (29.5%)	0.024
Difficulty learning new things in U.S.	44 (31.9%)	36 (38.3%)	8 (18.2%)	0.018
Difficulty raising children in U.S.	31 (22.5%)	24 (25.5%)	7 (15.9%)	0.207
Discrimination	9 (6.5%)	9 (9.6%)	0 (0.0%)	0.057
Documentation problems	35 (25.4%)	28 (29.8%)	7 (15.9%)	0.081
Driver's license issues	29 (21.0%)	23 (24.5%)	6 (13.6%)	0.146
Feeling U.S. is not your country	20 (14.5%)	16 (17.0%)	4 (9.1%)	0.217
Missing friends/family in Afghanistan	92 (66.7%)	63 (67.0%)	29 (65.9%)	0.897
No vacation time or sick leave	16 (11.6%)	10 (10.6%)	6 (13.6%)	0.608
Health insurance issues	4 (2.9%)	3 (3.2%)	1 (2.3%)	>0.999
Trouble at work	31 (22.5%)	21 (22.3%)	10 (22.7%)	0.960
Unemployment	36 (26.1%)	24 (25.5%)	12 (27.3%)	0.828
Worried or sentimental about life back in Afghanistan	59 (41.8%)	44 (45.8%)	15 (33.3%)	0.161

Table 4.3 presents the health-related characteristics of the total sample and the subsamples of people who used and didn't use mental health services in the U.S. About half the sample said their health was excellent or very good, and only about 15% said it was fair or poor. Although a greater percentage of individuals that did not use mental health services said their health was excellent or very good, the difference was not statistically significant. About 90% of the sample had health insurance, two-thirds were very comfortable or comfortable speaking English with their doctor, and about 90% said it was very easy or easy to understand written information from their doctors about their health. Looking at symptoms in the past two weeks, large proportions of both groups reported crying (50%), difficulty falling asleep (50%), feeling

hopeful and sad (about 40%), and feeling socially isolated (66%). The only significant difference was in the experience of bad memories in that those that had used mental health services were more likely to say they experienced bad memories every day ($p=0.004$).

Overall, respondents felt generally supported by family (about 84%), friends (about 72%), and community (about 67%). They also felt supported by family (about 82%), their community (about 65%), and their culture (about 61%) when feeling sad, anxious, or stressed. However, more respondents who had used mental health services felt supported by their friends when they were sad (80.4%) compared to those that did not use services (64.5%) ($p=0.042$).

Those who had used mental health services in the U.S. were more likely to have learned about mental health services in Afghanistan ($p=0.014$) and used mental health services in Afghanistan ($p<0.001$). Interestingly, only 84 (53%) of respondents revealed they learned about mental health services in the US. Among the individuals who answered this question, learning about mental health services in the U.S. was significantly associated with service use ($p<0.001$). Among those that wanted to use mental health services in the U.S., about 15% said they could not get them. Among those that did, 73.3%, said it was very easy or easy to connect to a provider.

Table 4.3 Bivariate Analysis: Health Variables and Mental Health Use in the U.S.

	Total sample (n=158)	Did not use MH services in U.S. (n=107)	Used MH services in U.S. (n= 51)	p-value
Self-rated health				0.131
Excellent/very good	77 (48.7%)	57 (53.3%)	20 (39.2%)	
Good	58 (36.7%)	38 (35.5%)	20 (39.2%)	
Fair/poor	23 (14.6%)	12 (11.2%)	11 (21.6%)	
Has health insurance	143 (90.5%)	96 (89.7%)	47 (92.2%)	0.776
Comfort speaking English with doctor				0.297
Very comfortable/comfortable	105 (66.5%)	74 (69.2%)	31 (60.8%)	
Uncomfortable	53 (33.5%)	33 (30.8%)	20 (39.2%)	
Ease understanding written information from a doctor's office				0.199
Very easy/easy	72 (45.6%)	45 (42.1%)	27 (52.9%)	

Not easy	86 (54.4%)	62 (57.9%)	24 (47.1%)	
During the last 2 weeks, times you:				
Cried				0.718
Everyday	6 (3.8%)	4 (3.7%)	2 (3.9%)	
2-5 days	70 (44.3%)	45 (42.1%)	25 (49.0%)	
Never	82 (51.9%)	58 (54.2%)	24 (47.1%)	
Had difficulty falling asleep				0.845
Everyday	14 (8.9%)	9 (8.4%)	5 (9.8%)	
2-5 days	65 (41.1%)	43 (40.2%)	22 (43.1%)	
Never	79 (50.0%)	55 (51.4%)	24 (47.1%)	
Felt hopeless				0.403
Everyday	10 (6.3%)	5 (4.7%)	5 (9.8%)	
2-5 days	56 (35.4%)	37 (34.6%)	19 (37.3%)	
Never	92 (58.2%)	65 (60.7%)	27 (52.9%)	
Feeling socially isolated				0.264
Everyday	10 (6.3%)	5 (4.7%)	5 (9.8%)	
2-5 days	41 (25.9%)	31 (29.0%)	10 (19.6%)	
Never	107 (67.7%)	71 (66.4%)	36 (70.6%)	
Felt sad				0.543
Everyday	14 (8.9%)	9 (8.4%)	5 (9.8%)	
2-5 days	85 (53.8%)	55 (51.4%)	30 (58.8%)	
Never	59 (37.3%)	43 (40.2%)	16 (31.4%)	
Become jigar khun				0.367
Everyday	12 (7.6%)	6 (5.6%)	6 (11.8%)	
2-5 days	83 (52.5%)	58 (54.2%)	25 (49.0%)	
Never	63 (39.9%)	43 (40.2%)	20 (39.2%)	
Experienced bad memories				0.004
Everyday	16 (10.1%)	5 (4.7%)	11 (21.6%)	
2-5 days	55 (34.8%)	40 (37.4%)	15 (29.4%)	
Never	87 (55.1%)	62 (57.9%)	25 (49.0%)	
Beaten or hurt yourself				0.490
Everyday	1 (0.6%)	1 (0.9%)	0 (0.0%)	
2-5 days	3 (1.9%)	1 (0.9%)	2 (3.9%)	
Never	154 (97.5%)	105 (98.1%)	49 (96.1%)	
Had difficulty meeting your responsibilities at home or at work because of jigar khun				0.228
Everyday	5 (3.2%)	2 (1.9%)	3 (5.9%)	
2-5 days	40 (25.3%)	30 (28.0%)	10 (19.6%)	
Never	113 (71.5%)	75 (70.1%)	38 (74.5%)	
Feelings of general support from:				
Family				0.664
Very supported/supported	133 (84.2%)	91 (85.0%)	42 (82.4%)	
Other	25 (15.8%)	16 (15.0%)	9 (17.6%)	
Friends				0.495
Very supported/supported	114 (72.2%)	79 (73.8%)	35 (68.6%)	
Other	44 (27.8%)	28 (26.2%)	16 (31.4%)	
Community members				0.518
Very supported/supported	106 (67.1%)	70 (65.4%)	36 (70.6%)	
Other	52 (32.9%)	37 (34.6%)	15 (29.4%)	
Feelings of support when are feeling sad, anxious, or stressed from:				
Family				0.382
Very supported/supported	130 (82.3%)	90 (84.1%)	40 (78.4%)	
Other	28 (17.7%)	17 (15.9%)	11 (21.6%)	
Friends				0.042
Very supported/supported	110 (69.6%)	69 (64.5%)	41 (80.4%)	

Other	48 (30.4%)	38 (35.5%)	10 (19.6%)	
Community members				0.788
Very supported/supported	103 (65.2%)	69 (64.5%)	34 (66.7%)	
Other	55 (34.8%)	38 (35.5%)	17 (33.3%)	
Culture				0.347
Very supported/supported	97 (61.4%)	63 (58.9%)	34 (66.7%)	
Other	61 (38.6%)	44 (41.1%)	17 (33.3%)	
Learned about mental health services in Afghanistan	59 (37.3%)	33 (30.8%)	26 (51.0%)	0.014
Used mental health services in Afghanistan	22 (13.9%)	7 (6.5%)	15 (29.4%)	<0.001
Learned about mental health services in U.S. (n=84)	59 (71.1%)	35 (59.3%)	24 (100.0%)	<0.001
Wanted to use mental health services in U.S.?				<0.001
No	117 (74.1%)	91 (85.0%)	26 (51.0%)	1
Yes, but could not get them.	25 (15.8%)	15 (14.0%)	10 (19.6%)	
Yes, and could get them.	16 (10.1%)	1 (0.9%)	15 (29.4%)	
Connected to mental health services through resettlement agency			3 (20.0%)	
When you used mental health services, ease connecting to provider				
Very easy or easy			11 (73.3%)	
Very difficult or difficult			4 (26.7%)	
When you used mental health services, frequently of use				
Once a week			6 (40.0%)	
Once every two weeks			3 (20.0%)	
Once a month			4 (26.7%)	
Once every 2-3 months			2 (13.3%)	
When you used mental health services, who encouraged you				
Coworker			2 (13.3%)	
Doctor			1 (6.7%)	
Family member			2 (13.3%)	
Friend			3 (20.0%)	
Other			3 (20.0%)	
Primary doctor			1 (6.7%)	
Resettlement agency			1 (6.7%)	
Self			2 (13.3%)	
Type of provider seen				
Psychiatrist or Neurologist			6 (40.0%)	
General Practitioner			3 (20.0%)	
Therapist or psychotherapist			2 (13.3%)	
Counselor, social worker, case worker			7 (46.7%)	
	¹ n (%); Mean ± SD			
	² Pearson's Chi-squared test; Fisher's exact test; Welch Two Sample t-test			

Logistic Regression

The characteristics examined in the logistic regression analysis for mental health use in the U.S. were gender (reference group female), education level (reference group high school or

less), employed in Afghanistan (reference group no), household monthly income in Afghanistan (reference group less than 12,000AFN), and employed in the U.S. (reference group no), and annual household income in the US (reference group less than 28,000USD).

Table 4.4. Logistic Regression for Mental Health Use in U.S.

Characteristic	OR ¹	95% CI ¹	p-value
Gender			
Female	—	—	
Male	0.54	0.22, 1.33	0.18
Education level			
Graduated high school or less	—	—	
Some or graduated college	1.84	0.75, 4.64	0.19
Master or PhD degree	2.57	0.75, 8.88	0.13
Employed in Afghanistan			
No	—	—	
Yes	1.09	0.41, 2.99	0.87
Monthly household income in Afghanistan			
Less than 12,000AFN	—	—	
12,001AFN to 40,000AFN	0.72	0.23, 2.20	0.565
More than 40,000AFN	0.45	0.13, 1.58	0.217
Unknown	1.1	0.20, 5.85	0.912
Employed in U.S.			
No	—	—	
Yes	0.88	0.36, 2.17	0.787
Annual household income in U.S.			
Less than 28,000USD	—	—	
28,001USD to 55,000USD	0.26	0.08, 0.79	0.024
More than 55,000USD	0.39	0.13, 1.10	0.084

¹ OR = Odds Ratio, CI = Confidence Interval
Hosmer-Lemeshow goodness of fit test is not significant (p-value = 0.542)

According to the analysis, the odds ratio (OR) for males compared with females was 0.54 (95% CI: 0.22 - 1.33), suggesting that males were approximately half as likely to use mental health services. However, the difference was not statistically significant ($p=0.18$). Although I hypothesized that employment status of respondents would be an important factor in mental health service use in the U.S., neither being employed in Afghanistan or in the U.S. was significantly associated with use in the U.S. Although monthly household income in Afghanistan was not associated with mental health service use in the U.S., annual household income in the U.S. was significant ($p=0.024$), suggesting that respondents earning between \$28,000 and \$55,000 a year were more likely to use services than those earning less than \$28,000 or more than \$55,000. The Hosmer-Lemeshow goodness of fit test was not significant ($p=0.542$), implying that the model's estimates fit the data at an acceptable level.

Discussion

The findings of this study are somewhat in agreement with the literature that mental health use is associated with income and gender; however, there did not appear to be an association between mental health use and years in the U.S. in this sample. For gender, the association was not significant, although more females used services than males. Only one of the income and education variables showed a significant association, and that was income in the US, with those in the middle-income range (\$28,000 to \$55,000) more likely to use services.

It should be noted that information about income could be inaccurate. In Afghan culture, people refrain from sharing information about their income for various reasons, one being security concerns. Wealthier families have often been targeted by criminal groups for kidnapping, with demands for large ransoms. Consequently, many individuals prefer to keep a low profile and avoid disclosing details about their income sources. In this study, due to privacy

and cultural sensitivities, many refugees may have felt uncomfortable sharing accurate information about their true income. Additionally, some participants may have different immigration statuses or receive benefits from the U.S. government, such as food stamps, and they may have feared that disclosing information about income could jeopardize benefits.

Failure to find an association between years in the U.S. and mental health service use could be because more than half of the respondents did not provide their year of arrival and/or because all but four respondents arrived since 2001. Again, there could have been reluctance to disclose this information because of worry that this may affect their immigration status or benefits.

Although not included in the logistic regression, a few other variables were associated with service use in bivariate analysis. For example, those that used services were more likely to have felt stigma when expressing feelings of sadness, stress, or anxiety, but they also were more likely to feel safe and integrated in their U.S. communities. It is reasonable that feelings of stigma led them to seek mental health services, but it is not clear if feelings of safety and integration led to service use or resulted from service use.

Prior knowledge and use of mental health services also were significantly associated with service use in the U.S. This makes sense because people need to know about mental health issues and services that can help before they use them. As other researchers have found, refugees do not seek mental health services due to lack of knowledge or low “mental health literacy,” their cultural beliefs, or the notion that mental health is a stigmatized issue (Goodkind et al., 2014; Slewa-Younan et al., 2017). Anecdotal information from service providers suggests that psychoeducation is an offered service, and some refugees indicated they had learned about

mental health services in the U.S. However, it is unclear why 40% of the sample did not answer the question about whether or not they learned about mental health services in the U.S.

Strengths and Limitations

A strength of this study is the comprehensive analysis of socio-demographic factors associated with Afghan refugee mental health service utilization and the availability of the survey in Dari and Pashto, as well as English. Another strength was the support of some of the refugee organizations to endorse the study with their clientele.

There are, however, several limitations to this study that should be considered. A disadvantage of using self-reported data is that it may introduce biases and inaccuracies, especially when it comes to sensitive topics like mental health services, income, and years in the U.S. Also, respondents may provide inaccurate information due to their desire to present themselves in a socially desirable way. Moreover, because this study was cross-sectional, causal inferences cannot be made, limiting this ability to establish temporal relationships between predictors and outcomes. Furthermore, the use of convenience sampling could also introduce bias. This method may lead to a sample that does not fully represent all Afghan refugees in the U.S., as those who opted to participate may differ from those who chose not to. For example, participants who completed the survey might be more inclined to discuss mental health openly, potentially influencing the findings towards a higher reported willingness to seek or use mental health services compared to the broader Afghan refugee population.

Using an online survey may have limited respondents to those who are comfortable with its interface, as many refugees have limited computer skills. If they had to rely on others to complete the survey, they may have been dissuaded from participating or from giving accurate information. In addition, I was an outsider to the California refugee community, so individuals

may have lacked trust in this research. Also, I learned during the process of collecting data that some individuals did not want to participate because of ongoing legal documentation procedures, which they felt might be jeopardized by their participation. Finally, participation was limited to those willing to complete the survey without receiving an incentive.

Recommendations

Several recommendations for practice can be derived from our findings, aiming to address resettlement-related challenges among Afghan refugees in the U.S. First, collaboration between refugee organizations, healthcare providers, and community stakeholders is crucial for developing culturally responsive services tailored to meet the unique needs of this population. Providers should understand that issues of income and gender may affect willingness to use services, as well as knowledge of mental health issues and services, feelings of safety, stigma, and other social factors.

Thus, more programs are needed to educate about mental health issues and way to address them, to normalize the seeking of services, and to reduce stigma attached to mental health concerns. Community support from religious and cultural organizations plays a pivotal role in either encouraging or discouraging individuals from seeking mental health care based on community norms and values. Language barriers present significant challenges, as many individuals may struggle with English proficiency, limiting their access to mental health education as well as services.

Also, navigating the U.S. healthcare system, especially for mental health services, is complex. Policymakers should integrate mental health services into existing healthcare infrastructure to ensure equitable access for all Afghan refugees, irrespective of socioeconomic status or language proficiency.

In terms of research, more research is needed on the ways that cultural beliefs and practices shape attitudes towards mental health services. These beliefs often determine whether individuals seek mental health support and how they perceive it within their communities. offered primarily in English. By investigating these areas through research and community engagement, we can gain deeper insights into why certain groups do not fully utilize mental health services. Community-engaged research approaches are essential for developing interventions that are culturally appropriate and responsive to the needs of Afghan refugee communities, and these should be tested through longitudinal studies to gauge improvement in mental health service utilization over time.

The study encountered multiple challenges in obtaining adequate and meaningful data. Thus, future researchers should be sure to work with providers to address issues of trust, should offer incentives, and do more to assure that participation in research will not jeopardize their benefits.

Chapter 5. Summary

In this dissertation, three interconnected studies examined the mental health challenges of Afghan refugees resettled in the U.S. and their access to mental health services. To comprehensively analyze these findings, we revisit Miller and Rasmussen's (2016) framework on mental health, displacement, and armed conflict, alongside the Ecological Model of Barriers and Facilitators to Mental Health Service Use among Afghan Refugees in the U.S.

Findings from the interviews with refugees and mental health service providers identified many of the contributors to poor mental health as noted in the Miller and Rasmussen's (2016) framework on mental health, displacement, and armed conflict. For example, interviewees noted continuing trauma from experiences of armed conflict in Afghanistan, loss of family, and hardships leaving the country. They also talked about how many displacement and resettlement issues noted in the model contributed to poor mental health, including poverty, un- and under-employment, discrimination, uncertainty about asylum status, and loss of social support. Additionally, we heard about mental distress caused by language barriers, cultural differences, mental health stigma, and logistical issues such as transportation and financial constraints.

Findings from the interviews and survey also fit well into the Ecological Model of Barriers and Facilitators to Service Use. Barriers at the individual level included lack of knowledge about mental health and inadequate English-language proficiency among many, as well as modest influences of sex and income. At the interpersonal level, lack of family support and provider connections were mentioned. At the community level, stigma and feelings of safety were important predictors of service use, and refugee programs were identified as helpful to some in overcoming service-use barriers. They also highlighted the importance of community and religious support as sources of resilience.

Recommendations for Practice and Policy

The research supports a number of recommendations for practice, policy, and research. Related to practice and policy, a comprehensive approach to addressing the mental health needs of Afghan refugees is needed.

Educational campaigns, advocacy, and community empowerment can foster an environment that supports mental well-being. Targeted education and awareness campaigns can reduce stigma surrounding mental health within refugee communities and the broader society. These campaigns should emphasize the importance of seeking mental health care and promote positive attitudes towards mental health care. Accurate information about mental health and available support services should be disseminated through various media channels, community events, and cultural platforms. Engaging community leaders and using culturally relevant messaging can promote positive attitudes towards mental health care. Integrating mental health education into community activities and religious gatherings can be especially effective.

Trauma-informed mental health services should be provided, addressing the psychological impact of war-related trauma and displacement. Developing and implementing culturally competent care models also is essential. This involves training mental health providers to help them understand cultural norms, beliefs, and experiences related to mental health in refugee communities. It also is important for health systems to hire bilingual staff and collaborating with community organizations to create supportive and accessible service environments. Mobile clinics and telehealth services can help refugees overcome logistical barriers to health care. Peer support groups and community-based mental health workshops can provide emotional and practical support, fostering community cohesion.

Comprehensive support should be offered through collaboration with mental health professionals, social workers, community health workers, and other stakeholders, including housing and employment experts.

Relatedly, refugee communities should have access to resources, participate in decision-making processes, and advocate for their rights. Support for community-led initiatives can promote self-reliance, resilience, and social integration. Peer-to-peer support networks, mentorship programs, and community-based organizations can provide emotional support, practical assistance, and social integration opportunities. These public health initiatives should build on the existing strengths of Afghan refugee communities and enhance their support networks. Involving community leaders and religious figures can enhance mental health advocacy and support systems.

Advocating for policies that address structural barriers is crucial. Improving access to mental health services through affordable healthcare, language services, and financial assistance for transportation can significantly benefit refugees. Comprehensive support programs addressing housing, education, and employment should be developed to meet refugees' unique challenges.

Finally, efforts should be made to address the root causes of forced migration, such as conflict and instability in home countries. Support for diplomatic efforts, peacebuilding initiatives, and humanitarian aid can mitigate the causes of displacement. Long-term development initiatives in conflict-affected regions should focus on poverty reduction, economic empowerment, education, healthcare, and social services. These efforts can help prevent displacement and maintain stability, reducing the need for long-distance resettlement.

Recommendation for Research and Evaluation

Further research should explore service utilization patterns among Afghan refugees and the long-term effects of mental health interventions. This includes examining interactions between sociodemographic variables, cultural factors, trauma experiences, and acculturation levels. Longitudinal studies can uncover evolving patterns and barriers to mental health service utilization. An intersectional lens can examine how multiple dimensions of identity intersect to create unique barriers and coping mechanisms. Longitudinal studies and mixed-methods research designs can provide a better understanding of the complex dynamics of refugee mental health and resilience. Attention needs to be paid to building trust in research and providing meaningful incentives for participation.

Conclusion

In conclusion, this dissertation provided insights into Afghan refugees' lived experiences navigating the difficult terrain of adapting to their new lives, as well as accessing mental health service use. In sharing their stories of resilience, adversity, and hope, these individuals illuminated the way forward, advocating for a world where culturally sensitive services, supportive policies, and empowered communities nurture refugees' well-being.

This dissertation demonstrates the resilience and multifaceted challenges faced by Afghan refugees in the U.S. By integrating Miller and Rasmussen's (2016) framework on armed conflict, displacement, and mental health with the Ecological Model of Barriers to and Facilitators of Mental Health Service Use, we gain a comprehensive understanding of the barriers and facilitators to mental health service utilization among this population. The recommendations aim to enhance public health practice by improving access to culturally competent care, addressing stigma, and strengthening community supports. These efforts contribute to the well-being and successful integration of Afghan refugees into their new

communities while addressing the larger issues of displacement and instability that drive forced migration.

In closing, let us heed the call to action embedded within these pages. Let us stand in solidarity with Afghan refugees, amplifying their voices, honoring their resilience, and advocating for a world where mental health knows no borders. For in their stories lie the seeds of hope, resilience, and transformation, illuminating the path toward a brighter, more inclusive future for all.

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Appendix A. Consent Form (Study 1)

Aloha! My name is Shugufa Basij-Rasikh and you are invited to take part in a research study. I am a graduate student at the University of Hawai'i at Mānoa in the Thompson School of Social Work & Public Health. As part of the requirements for earning my graduate degree, I am doing a research project.

What am I being asked to do?

If you participate in this project, I will meet with you for an interview at a location and time convenient for you. It can be on Zoom or in-person.

Taking part in this study is your choice.

Your participation in this project is completely voluntary. You may stop participating at any time. If you stop being in the study, there will be no penalty or loss to you. Your choice to participate or not participate will not affect your rights to services which made you eligible in your community.

Why is this study being done?

The purpose of this dissertation is to better understand the needs for, access to, and barriers to utilization of mental health services for Afghan refugees in the U.S. As part of my research, I will interview refugee resettlement service providers who have helped with any wave of refugees and are knowledgeable about refugees' mental health issues .

What will happen if I decide to take part in this study?

The interview will consist of 10 open ended questions. It will take 45 min to an hour.

The interview questions will include questions like,

What individual needs do refugees have?

What interpersonal needs do refugees have?

What societal needs do refugees have?

How do you decide when a refugee needs mental health services?

Only you and I will be present during the interview. With your permission, I will audio-record the interview so that I can later transcribe the interview and analyze the responses. You will be 1 of about 10 people I will interview for this study.

What are the risks and benefits of taking part in this study?

I believe there is little risk to you for participating in this research project. You may become stressed or uncomfortable answering any of the interview questions or discussing topics with me

during the interview. If you do become stressed or uncomfortable, you can skip the question or take a break. You can also stop the interview or you can withdraw from the project altogether. There will be no direct benefit to you for participating in this interview. The results of this project inform policies regarding mental health of Afghan refugees resettled in the U.S. in the future.

Privacy and Confidentiality

I will keep all study data secure in a locked filing cabinet in a locked office/encrypted on a password protected computer. Only my University of Hawai'i advisor and I will have access to the information. Other agencies that have legal permission have the right to review research records. The University of Hawai'i Human Studies Program has the right to review research records for this study.

After I write a copy of the interviews, I will erase or destroy the audio-recordings. When I report the results of my research project, I will not use your name. I will not use any other personal identifying information that can identify you. I will use pseudonyms (fake names) and report my findings in a way that protects your privacy and confidentiality to the extent allowed by law.

Compensation:

There will not be any compensation for your participation in this interview.

Future Research Studies:

Even after removing identifiers, the data collected for this study will not be used or distributed for future research studies.

Questions:

If you have any questions about this study, please call me at +1-808-475-8005 or email me at sbasijra@hawaii.edu. You may also contact my advisor, Dr. Kathryn L. Braun, at +1-808-330-1759 or +1-808-330-1759. You may contact the UH Human Studies Program at +1-808-956-5007 or uhirb@hawaii.edu to discuss problems, concerns and questions; obtain information; or offer input with an informed individual who is unaffiliated with the specific research protocol. Please visit <http://go.hawaii.edu/jRd> for more information on your rights as a research participant.

If you agree to participate in this project, please sign and date this signature page and return it to: sbasijra@hawaii.edu

Keep a copy of the informed consent for your records and reference.

Signature(s) for Consent:

I give permission to join the research project entitled, "*Mental Health Service Delivery for Afghan Refugees in the U.S.*"

Please initial next to either "Yes" or "No" to the following:

_____ Yes _____ No I consent to be audio-recorded for the interview portion of this research.

Name of Participant (Print): _____

Participant's Signature: _____

Signature of the Person Obtaining Consent: _____

Date: _____

Mahalo!

Appendix B. Consent Form (Study 2)

Aloha! My name is Shugufa Basij-Rasikh, and you are invited to take part in a research study. I am a graduate student at the University of Hawai'i at Mānoa in the Thompson School of Social Work & Public Health. As part of the requirements for earning my graduate degree, I am doing a research project.

What am I being asked to do?

If you participate in this project, I will meet with you for an interview at a location and time convenient for you. It can be on Zoom or in-person.

Taking part in this study is your choice.

Your participation in this project is completely voluntary. You may stop participating at any time. If you stop being in the study, there will be no penalty or loss to you. Your choice to participate or not participate will not affect your rights to services which made you eligible in your community.

Why is this study being done?

The purpose of this dissertation is to better understand the needs for, access to, and barriers to utilization of mental health services for Afghan refugees in the U.S. As part of my research, I will interview refugee who are in California. I will then use qualitative data collection techniques through one on-one-interviews to identify issues and barriers associated with access to mental health services among Afghan refugees that arrived in the U.S. with the any wave.

What will happen if I decide to take part in this study?

The interview will consist of 8 open ended questions. It will take one hour to one and half hour. The interview questions will include questions like:

- Please tell me your experience emigrating from Afghanistan and adjusting to the U.S..
- What kinds of things has the agency helped you with? Resettlement (job, housing, language), community (support networks, Eid parties), family (relations, support, reunification), individual feelings?
- In your opinion, what barriers prevent Afghan refugees from accessing mental health care?

Only you and I will be present during the interview. With your permission, I will audio-record the interview so that I can later transcribe the interview and analyze the responses. You will be one of about 8-12 adult Afghan refugees I will interview for this study.

What are the risks and benefits of taking part in this study?

I believe there is little risk to you for participating in this research project. You may become stressed or uncomfortable answering any of the interview questions or discussing topics with me during the interview. If you do become stressed or uncomfortable, you can skip the question or take a break. You can also stop the interview or you can withdraw from the project altogether. There will be no direct benefit to you for participating in this interview. The results of this project inform policies regarding mental health of Afghan refugees resettled in the U.S. in the future.

Privacy and Confidentiality:

I will keep all study data secure in a locked filing cabinet in a locked office/encrypted on a password protected computer. Only my University of Hawai'i advisor and I will have access to the information. Other agencies that have legal permission have the right to review research records. The University of Hawai'i Human Studies Program has the right to review research records for this study.

After I write a copy of the interviews, I will erase or destroy the audio-recordings. When I report the results of my research project, I will not use your name. I will not use any other personal identifying information that can identify you. I will use pseudonyms (fake names) and report my findings in a way that protects your privacy and confidentiality to the extent allowed by law.

Compensation:

You will receive a gift for your time and effort in participating in this research project.

Future Research Studies:

Even after removing identifiers, the data collected for this study will not be used or distributed for future research studies.

Questions:

If you have any questions about this study, please call me at +1-808-475-8005 or email me at sbasijra@hawaii.edu. You may also contact my advisor, Dr. Kathryn L. Braun, at +1-808-330-1759 or +1-808-330-1759. You may contact the UH Human Studies Program at +1-808-956-5007 or uhirb@hawaii.edu to discuss problems, concerns and questions; obtain information; or offer input with an informed individual who is unaffiliated with the specific research protocol. Please visit <http://go.hawaii.edu/jRd> for more information on your rights as a research participant.

If you agree to participate in this project, please sign and date this signature page and return it to Shugufa Basij-Rasikh or email it to her via sbasijra@hawaii.edu . Keep a copy of the informed consent for your records and reference.

Signature(s) for Consent:

I give permission to join the research project entitled, “*Mental Health Service Delivery for Afghan Refugees in the U.S.*”

Please initial next to either “Yes” or “No” to the following:

_____ Yes _____ No I consent to be audio-recorded for the interview portion of this research.

Name of Participant (Print): _____

Participant’s Signature: _____

Signature of the Person Obtaining Consent: _____

Date: _____

Mahalo!

Appendix C. Consent Form (Study 3)

Aloha! My name is Shugufa Basij-Rasikh and you are invited to take part in a research study. I am a graduate student at the University of Hawai'i at Mānoa in the Thompson School of Social Work & Public Health. As part of the requirements for earning my graduate degree, I am doing a research project.

What am I being asked to do?

If you participate in this project, You will receive the link for the survey via email.

Taking part in this study is your choice.

Your participation in this project is completely voluntary. You may stop participating at any time. If you stop being in the study, there will be no penalty or loss to you. Your choice to participate or not participate will not affect your rights to services which made you eligible in your community.

Why is this study being done?

The purpose of this dissertation is to better understand the needs for, access to, and barriers to utilization of mental health services for Afghan refugees in the U.S. As part of my research, I will send a survey to refugee who were resettled in the CA. I will then administer a close-ended questionnaire with 150-200 Afghan refugees to explore how their socioeconomic (SES) status, level of education, and years in the U.S. influence mental health service awareness and utilization.

What will happen if I decide to take part in this study?

The survey will consist of 33 open ended questions. It will take 30-45 minutes.

The survey questions will include questions like:

- Are you an Afghan refugee or asylum seeker living in California, U.S.?
- When did you arrive in the U.S. as a refugee or asylum seeker?
- Are you 18 years of age or older?
- What is your age, in years?
- Do you worry about paying for health services?
- Does your health insurance plan cover mental health services?

What are the risks and benefits of taking part in this study?

I believe there is little risk to you for participating in this research project. You may become stressed or uncomfortable answering any of the survey questions. If you do become stressed or

uncomfortable, you can skip the question or take a break. You can also stop the survey or you can withdraw from the project altogether.

There will be no direct benefit to you for participating in this interview. The results of this project inform policies regarding mental health of Afghan refugees resettled in the U.S. in the future.

Confidentiality and Privacy

I will keep all study data secure in a locked filing cabinet in a locked office/encrypted on a password protected computer. Only my University of Hawai'i advisor and I will have access to the information. Other agencies that have legal permission have the right to review research records. The University of Hawai'i Human Studies Program has the right to review research records for this study.

After I write a copy of the interviews, I will erase or destroy the audio-recordings. When I report the results of my research project, I will not use your name. I will not use any other personal identifying information that can identify you. I will use pseudonyms (fake names) and report my findings in a way that protects your privacy and confidentiality to the extent allowed by law.

Compensation:

There is no compensation for your participation.

Future Research Studies:

Even after removing identifiers, the data collected for this study will not be used or distributed for future research studies.

Questions:

If you have any questions about this study, please call me at +1-808-475-8005 or email me at sbasijra@hawaii.edu. You may also contact my advisor, Dr. Kathryn L. Braun, at +1-808-330-1759 or +1-808-330-1759. You may contact the UH Human Studies Program at +1-808-956-5007 or uhirb@hawaii.edu to discuss problems, concerns and questions; obtain information; or offer input with an informed individual who is unaffiliated with the specific research protocol. Please visit <http://go.hawaii.edu/jRd> for more information on your rights as a research participant.

If you agree to participate in this project, please sign and date this signature page and return it to:

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. Keep a copy of the informed consent for your records and reference.

To Access the Survey: Please go to the following web page: ([surveymonkey100.com](https://www.surveymonkey.com)). You should find a link and instructions for completing the survey. Going to the first page of the survey implies your consent to participate in this study.

Please print or save a copy of this page for your reference.

Mahalo!

Appendix D. Recruitment Email (Study 1)

Aloha!

My name is Shugufa Basij-Rasikh. At the University of Hawai'i at Mānoa. I am completing my doctoral degree under the supervision of Dr. Kathryn Braun. I am researching Mental Health Services Delivery for Afghan Refugees in the U.S. for my IRB-approved doctoral dissertation. I would like to interview you since you are one of the important service providers for Afghan refugees in order to learn more about their mental health needs and service utilization patterns. Would you be available to take an interview within the next month at your convenience? Your time will only be required for an hour. Would you mind recommending someone with whom I might speak about Afghan refugee mental health service delivery if you feel you aren't the right person to interview? Please accept my sincere thanks for your consideration and time. Even if you are not interested in participating, a response would be greatly appreciated.

Sincerely, Shugufa

Shugufa Basij-Rasikh, MPH, MSM

Student, PhD in Public Health

Office of Public Health Studies

University of Hawai'i at Mānoa

Phone: 808-475-8005

Appendix E. Recruitment Email (Study 2)

Aloha!

My name is Shugufa Basij-Rasikh. At the University of Hawai'i at Mānoa. I am completing my doctoral degree under the supervision of Dr. Kathryn Braun. I am researching Mental Health Services Delivery for Afghan Refugees in the U.S. for my IRB-approved doctoral dissertation. I would like to interview you since you are one of the Afghan refugees in order to identify supports and barriers to seeking professional help to relieve anxiety, depression, and stress. Would you be available to take an interview within the next month at your convenience? Your time will only be required for an hour to an hour and a half. Would you mind recommending someone with whom I might speak with if you feel you aren't the right person to interview? Please accept my sincere thanks for your consideration and time. Even if you are not interested in participating, a response would be greatly appreciated.

Sincerely, Shugufa

Shugufa Basij-Rasikh, MPH, MSM
Student, PhD in Public Health
Office of Public Health Studies
University of Hawai'i at Mānoa
Phone: 808-475-8005

Appendix F. Recruitment Flyer (Study 3)

The University of Hawai'i is conducting a study:

Mental Health Service Delivery for Afghan Refugees in the U.S.

Are you an Afghan refugee? Are you at least 18 years old?

If the answers are YES...

Shugufa Basij-Rasikh would like to invite you to participate in a research study as part of her dissertation. The purpose of this dissertation is to better understand the needs for, access to, and barriers to utilization of mental health services for Afghan refugees in the U.S

Study volunteers will be:

- Scheduled for an interview date.
- Interviewed for an hour in person or zoom
- There is no compensation for your time.
- Provided an opportunity to discuss barriers that Afghan refugees needs to receive mental health services in U.S.

To learn more about the study, please return this sheet to Shugufa Basij-Rasikh at

sbasijra@hawaii.edu

Appendix G. Recruitment Script (Study 3)

At end of Study 1, I will ask the following questions to recruit participants for Study 3:

- Do you know Afghan refugees willing to fill out a questionnaire regarding their mental health experiences?
- If so, are these refugees 18 years of age or older; able to understand and respond to an English-language survey; and have they emigrated to the U.S. between [1979] and [current]
- Are you able to assist me in recruiting them for my dissertation study?

Appendix H. Survey (Study 3)

Thank you for agreeing to take my survey.

First, I need to ask you some screening questions.

- S1. Are you an Afghan refugee or asylum seeker living in California, U.S.? Yes
 No
- S2. What year did you arrive in the U.S. as a refugee or asylum seeker? _____
- S3. Are you 18 or older? Yes No

Congratulations, you meet the criteria to join the study. Now, please answer the following questions about yourself.

1. What is your gender?
 Female Male Other
2. Are you married?
 Yes No
3. What is your education level?
 Never attended formal school
 Elementary (Grades 1 through 8)
 Some high school (Grades 9 through 11)
 Graduated high school (Grade 12)
 Some college (1 to 3 years of college or technical school)
 Graduated college (4 years and completed degree program)
4. Were you employed in Afghanistan?
 Yes, full-time Yes, part-time No
5. If you were employed, what type of job did you have in Afghanistan?
6. What was the monthly income of your household in Afghanistan?
 Less than 12,000AFN (20%)
 12,001AFN to 15,000AFN (40%)
 15,001AFN to 40,000AFN (60%)
 40,001AFN to 80,000AFN (80%)
 More than 80,000AFN (100%)
7. Are you employed in the U.S.?
 Yes, full-time Yes, part-time No

8. If you are employed, what type of job do you have in the U.S.? _____

9. What is the annual income of your household in the U.S.?

Less than 28,000USD

28,001USD to 55,000USD

55,001USD to 89,000USD

89,001USD to 149,000USD

More than 149,000USD

10. How many dependents do you have? _____

11. How safe do you feel in the U.S. community in which you live?

Very safe

Safe

Neither safe nor unsafe

Unsafe

Very unsafe

12. How integrated do you feel in the U.S. community in which you live?

Very integrated

integrated

Neither integrated nor unintegrated

Unintegrated

Very unintegrated

Thank you. Now, I would like to ask you some questions about your health.

13. How would you rate your general health compared to others your age?

Excellent

Very good

Good

Fair

Poor

14. Do you have health insurance?

Yes

No

15. How comfortable are you speaking English to your doctor?

- Very uncomfortable
- Comfortable
- Uncomfortable
- I cannot speak English and need a translator

16. When you get written information at a doctor's office, would you say that it is very easy, somewhat easy, somewhat difficult, or very difficult to understand?"

- very easy
- somewhat easy
- somewhat difficult
- very difficult to understand

Now I am going to ask you about issues that you may have encountered as a refugee in the U.S.

17. What resettlement-related issues have affected you in the past few months?

- Missing friends and family in Afghanistan
- Worried or sentimental about life back in Afghanistan
- Difficulty learning new things in U.S.
- Difficulty adjusting to new situations in U.S.
- Difficulty raising children in U.S.
- Cultural conflicts within family
- Feeling U.S. is not your country
- Documentation problems
- Unemployment or trouble at work
- Health insurance
- Being able to afford to live in the U.S.
- No vacation time or sick leave
- Driver's license issues
- Discrimination
- Other

18. Many refugees experience stress, sadness, or anxiety from their experiences leaving their countries and adjusting to their new countries. I hope you can share with me how you are currently feeling.

During the last 2 weeks, how many times have you cried?

- never
- 1 day/week
- 2–3 days/week
- 4–5 days/week
- everyday

During the last 2 weeks, how many times have you had difficulty falling asleep?

- never
- 1 day/week
- 2–3 days/week
- 4–5 days/week everyday
- everyday

During the last 2 weeks, how many times have you had an argument with a family member?

- never
- 1 day/week
- 2–3 days/week
- 4–5 days/week everyday
- everyday

During the last 2 weeks, how many times have you felt hopeless?

- never
- 1 day/week
- 2–3 days/week
- 4–5 days/week everyday
- everyday

During the last 2 weeks, how many times have you isolated yourself socially?

- never
- 1 day/week
- 2–3 days/week

- 4-5 days/week everyday
- everyday

During the last 2 weeks, how many times have you felt sad?

- never
- 1 day/week
- 2-3 days/week
- 4-5 days/week everyday
- everyday

During the last 2 weeks, how many times have you become *jigar khun*?

- never
- 1 day/week
- 2-3 days/week
- 4-5 days/week everyday
- everyday

During the last 2 weeks, how many times have you experienced bad memories you cannot get rid of?

- never
- 1 day/week
- 2-3 days/week
- 4-5 days/week everyday
- everyday

During the last 2 weeks, how many times have you beaten or hurt yourself?

- never
- 1 day/week
- 2-3 days/week
- 4-5 days/week everyday
- everyday

During the last 2 weeks, how many times have you had difficult meeting your responsibilities at home or at work because of *jigar khun*?

- never
- 1 day/week

- 2–3 days/week
- 4–5 days/week everyday
- everyday

19. Now I'd like to ask you about social support. I'm interested to know how supported you feel.

In general, how supported do you feel by your family?

- Very supported
- Supported
- Neither unsupported or supported
- Unsupported
- Very unsupported

In general, how supported do you feel by your friends?

- Very supported
- Supported
- Neither unsupported or supported
- Unsupported
- Very unsupported

In general, how supported do you feel by your community members?

- Very supported
- Supported
- Neither unsupported or supported
- Unsupported
- Very unsupported

How supported do you feel by your family when are feeling sad, anxious, or stressed?

- Very supported
- Supported
- Neither unsupported or supported
- Unsupported
- Very unsupported

How supported do you feel by your friends when are feeling sad, anxious, or stressed?

- Very supported

- Supported
- Neither unsupported or supported
- Unsupported
- Very unsupported

How supported do you feel by your community members when you are feeling sad, anxious, or stressed?

- Very supported
- Supported
- Neither unsupported or supported
- Unsupported
- Very unsupported

How supported do you feel by your overall culture when you are feeling sad, anxious, or stressed?

- Very supported
- Supported
- Neither unsupported or supported
- Unsupported
- Very unsupported

Do you feel stigmatized when you express sadness, stress, or anxiety with your family?

- Yes
- No

Do you feel stigmatized when you express sadness, stress, or anxiety to your friends?

- Yes
- No

Do you feel stigmatized when you express sadness, stress, or anxiety with your community?

- Yes
- No

20. Many people who feel sad, anxious, or stressed or who lack social support benefit from mental health services. This could be seeing a psychiatrist, taking psychiatric medication, going to family counseling, or participating in group therapy. I'd like to ask you about your knowledge and use of mental health services.

Did you learn about mental health services in Afghanistan?

- Yes
- No
- unsure

Did you use mental health services in Afghanistan?

- Yes
- No
- Unsure

Have you used mental health services since you have moved to the U.S.?

- Yes
- No
- Unsure

Do you feel that you need mental health services now?

- Yes
- No
- Unsure

Did you want mental health services but could not get them?

- No, I didn't need mental health services
- Yes, I wanted them but couldn't get them
- Yes, I wanted them and got them

<input type="checkbox"/> No, I didn't need mental health services	<input type="checkbox"/> Yes, I wanted them but couldn't get them	<input type="checkbox"/> Yes, I wanted them and got them
Thank you. This is the end of the survey.	If you wanted or needed but could not use mental health services, what was the reason? <hr/>	When you used mental health services, how easily were you connected to your mental health provider? <input type="checkbox"/> Very difficult <input type="checkbox"/> Difficult <input type="checkbox"/> Neither difficult nor easy <input type="checkbox"/> Easy

		<p><input type="checkbox"/> Very easy</p> <p>When you used mental health services, how frequently did you use them?</p> <p><input type="checkbox"/> Every day or nearly every day</p> <p><input type="checkbox"/> Once a week</p> <p><input type="checkbox"/> Once every two weeks</p> <p><input type="checkbox"/> Once a month</p> <p><input type="checkbox"/> Once every three months</p> <p><input type="checkbox"/> Once a year</p> <p>When you used mental health services, who encouraged you to use mental health services?</p> <p><input type="checkbox"/> Resettlement agency</p> <p><input type="checkbox"/> Family member</p> <p><input type="checkbox"/> Friend</p> <p><input type="checkbox"/> Coworker</p> <p><input type="checkbox"/> Other</p> <hr/> <p>Were you connected to mental health services through you're the resettlement agency?</p> <p><input type="checkbox"/> yes</p> <p><input type="checkbox"/> no</p> <p>What type of mental health worker did you see?</p>
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		<input type="checkbox"/> Case worker <input type="checkbox"/> Counselor <input type="checkbox"/> Psychotherapist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> General practitioner <input type="checkbox"/> Neurologist <input type="checkbox"/> Other
	Thank you. This is the end of the survey.	Thank you. This is the end of the survey.