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

Rose Burford-Rice, Clemence Due, and Martha Augoustinos

School of Psychology, The University of Adelaide

Little is known regarding help-seeking for mental health services within refugee populations, especially for women who may be at higher risk for poor mental health outcomes and face multiple barriers to service access. The participants were eleven Afghan Hazara women (aged 18-60 years) with refugee backgrounds living in Adelaide, South Australia. Qualitative, semi-structured interviews were conducted to examine existing formal and informal help-seeking patterns as well as to investigate how Afghan Hazara women conceptualise mental health issues, and whether this influences help-seeking behaviours. Thematic analysis was employed to analyse the data. Findings suggest that women of all ages from the Afghan community may face multiple social and cultural barriers to help-seeking including stigma, differences in cultural conceptualisations of mental health, domestic violence, and language and communication difficulties, and that these may be pronounced for older women. Future research should include the voices of older women in the community – and particularly those with lower levels of English. The study points to key recommendations, including women-only education sessions and English classes with mental health and domestic violence related information, outreach education and mental health teams, incorporating mental health information into religious practices, and mental health services that enhance protective social support networks.

Key words: barriers, help-seeking, mental health, Afghan, women, refugees

There are currently over 25.9 million people classified as refugees, who have been forced to leave their home countries due to persecution or conflict (UNHCR, 2019). Of these, approximately 2.7 million have fled Afghanistan, most recently as a result of years of conflict (UNHCR, 2019), including the Soviet-Afghan war during the 1980s, civil wars, invasion by the United States, and political instability. In August 2021 this included the Taliban taking control of Afghanistan once again, as America (and allied forces including Australia) withdrew from the country. In particular, the Shi-ite Hazara minority endured increased levels of violence during the theocratic rule of the Taliban from 1996-2001 (Saikal, 2012), and it is anticipated that Afghan Hazara people – and particularly women – will once again be the target of discrimination and potential genocide under the new Taliban regime from 2021. Indeed, refugee numbers from Afghanistan are already increasing with several countries agreeing to take hundreds, if not thousands, of people already attempting to flee the country (UNHCR, 2021).

The 2016 census indicated that there were over 46,000 Afghanistan-born people living in Australia, of whom over 10,000 were Hazara (Department of Home Affairs, 2016). Although people with refugee or asylum seeking backgrounds (defined for brevity here as refugees) often show extraordinary strength and resilience in the face of extreme adversity (Hutchinson & Dorsett, 2012), systematic reviews suggest that refugee populations suffer poorer mental health status when compared with other groups of migrants and the general
populations of host countries (Fazel, Wheeler, Danesh, 2005; Kirmayer et al. 2011; Lindert, Ehrenstein, Priebe, Mielck, Brahler, 2009; Porter & Haslam, 2005). Although few studies have assessed mental health outcomes among Afghan refugees resettled in Western countries specifically, of those that have, results consistently suggest high levels of mental health disorders, ranging from 25.4-35% for Post-Traumatic Stress Disorder (PTSD) and 54.7-57% for depression (Gernaat, Malwand, Laban, Komproe, & de Jong, 2002; Gerritsen et al., 2006). A recent Australian study found that 44% of a sample of 150 Afghan refugees presented with clinically significant PTSD symptoms, and 14.7% had symptoms of depression (Slewa-Younan et al., 2017).

Poor mental health outcomes amongst refugee populations more generally have been linked to pre-migration trauma (including torture, loss of family members, witnessing or participating in conflict, and imprisonment), the migration pathway itself, and post-migration stressors (adjusting to a new culture, racism and discrimination, resettlement stress, and loss of social support) (Alemi, James, Cruz, Zepeda & Racadio, 2014; Porter & Haslam, 2005), and a meta-analysis of Afghan refugees’ mental distress supports this (Alemi et al., 2014). Many Afghan women have experienced human rights violations under the Taliban regime (Scholte et al. 2004), with one cross-sectional survey finding that Afghan women living in Kabul or refugee camps during the Taliban rule in 1998 reported significant symptoms of major depression (97%), and anxiety (86%) (Rasekh, Bauer, Manos & Iacopino, 1998). Women may then be at particular risk of psychological distress due to extra risks they face on their journey to a resettlement country, including sexual violence, rape, unwanted pregnancies, harassment, health issues, and separation from children and loved ones (Kastrup, 2006). In addition, after arrival in a resettlement country, mental health issues may be heightened due to the erosion of traditional and cultural values within the family and the negotiation of gender and social roles in host countries particularly for elderly women (Alemi et al. 2014).

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

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

Using qualitative research methods, this study will explore help-seeking within the Afghan refugee community in South Australia, with a focus on women and those who identify as Hazara, given the persecution this group has faced and their subsequent representation in humanitarian migration to Australia as noted above. Specifically it aims to: 1) contribute to the literature concerning culturally specific knowledge about conceptualizations of mental health within this population, 2) explore preferred strategies for coping with mental health problems, and perceived efficacy of Australian mental health services, and 3) better understand and recognise barriers to help-seeking behaviours.

**Theoretical Perspective**

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

An individual’s likelihood of access to health services is considered to be a function of three individual and contextual characteristics. *Predisposing factors* are socio-cultural characteristics that include demographic factors, social structure, and health beliefs. Social characteristics include how supportive the community is towards health and access to health services, educational level, ethnicity, employment level, and crime rate, as these are existing conditions that predispose people to engage in or disengage from service use (Andersen, 1995). *Enabling factors* are the logistical aspects of obtaining care, including whether an individual has a regular source of care, ability to transport oneself, health insurance, and knowledge of health care services. It also includes whether there are available health facilities within their community (Andersen, 1995). *Need factors* are functional or health issues that promote the need for access to health care (e.g. level of discomfort of symptoms). Need factors are considered the most immediate cause of service use and are the conditions that laypeople recognise as requiring healthcare (Andersen, 1995). Figure 1 presents an adapted model of Andersen’s (1995) Model of Health Service Utilisation based on the likely factors affecting Afghan women’s service use in relation to previous literature.
Help-seeking in Afghan Hazara women

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

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

Participants

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

Table 1

Participant demographic information

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Visa Status</th>
<th>Time spent in Australia</th>
<th>Language</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parisa</td>
<td>30</td>
<td>Temporary Protection Visa (785)</td>
<td>4 years</td>
<td>Hazaragi, English</td>
<td>Student</td>
</tr>
<tr>
<td>Laila</td>
<td>18</td>
<td>Permanent Protection Visa (866)</td>
<td>4 years</td>
<td>Dari, English</td>
<td>Student</td>
</tr>
<tr>
<td>Jamilah</td>
<td>59</td>
<td>Permanent Protection Visa (866)</td>
<td>4 years</td>
<td>Dari</td>
<td>Unemployed (Stay at home mother)</td>
</tr>
<tr>
<td>Qamar</td>
<td>31</td>
<td>Woman at risk visa (204)</td>
<td>4 years</td>
<td>Dari, English</td>
<td>Student</td>
</tr>
<tr>
<td>Naila</td>
<td>60</td>
<td>Woman at risk visa (204)</td>
<td>4 years</td>
<td>Dari</td>
<td>Unemployed (Stay at home mother)</td>
</tr>
<tr>
<td>Giti</td>
<td>23</td>
<td>Permanent Protection Visa (866)</td>
<td>9 years</td>
<td>Dari, Urdu, Hindi, English</td>
<td>Student</td>
</tr>
<tr>
<td>Mahlia</td>
<td>32</td>
<td>Australian Citizen</td>
<td>11 years</td>
<td>Dari, Hazaragi, Urdu, English</td>
<td>Student and childcare worker</td>
</tr>
<tr>
<td>Saba</td>
<td>21</td>
<td>Australian Citizen</td>
<td>10 years</td>
<td>Dari, Irani, Hindi, English</td>
<td>Student</td>
</tr>
<tr>
<td>Rana</td>
<td>20</td>
<td>Refugee Visa (200)</td>
<td>5 months</td>
<td>Dari and Persian</td>
<td>Student</td>
</tr>
<tr>
<td>Lila</td>
<td>18</td>
<td>Australian Citizen</td>
<td>16 years</td>
<td>Dari and English</td>
<td>Student</td>
</tr>
<tr>
<td>Azadah</td>
<td>18</td>
<td>Australian Citizen</td>
<td>9 years</td>
<td>Hazaragi, Urdu, English</td>
<td>Student</td>
</tr>
</tbody>
</table>

Procedure

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

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

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

**Ethical considerations**

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

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

It was made clear to participants that participation was voluntary (Mackenzie, McDowell, & Pittaway 2007), as those from more collectivist cultures may be reluctant to decline their participation in order to benefit their broader community (Ellis et al., 2007). In an effort to balance the power dynamic, and to build rapport between researcher and participant, author RBR spent time having casual conversations before beginning the interview (Mackenzie et al. 2007).

**Data Analysis**

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

Overall, two main themes were identified, and within these, multiple sub-themes were described. The overarching theme of ‘social & cultural’ factors includes the sub-themes: stigma, cultural conceptualisations, domestic violence, husbands often acting as gatekeepers, and informal help-seeking preferences. The overarching theme of ‘structural & organisational’ factors includes the sub-themes; lack of knowledge of services/lack of appropriate services, English language proficiency, financial concerns, and transportation problems. With regard to the latter theme, structural and organizational barriers have been well-documented in previous literature (Colucci, Minas, Szwarc, Paxton & Guerra, 2012; Sheikh-Mohammed, MacIntyre, Wood, Leask & Isaacs, 2006; World Health Organization, 2018; Franks, Gawn & Bowden, 2007; Chuah, Teng Tan, Teo & Legido-Quigley, 2018). Therefore, this paper will focus on the
more unique findings of social and cultural barriers to help-seeking for mental health services for Hazara women with refugee backgrounds.

**Findings and Discussion**

**Social and cultural barriers to help-seeking**

**Stigma**

Family reputation was described as highly valued in Hazara culture, with women responsible for caring for her children and husband. As a result, a woman’s reputation also reflects her family’s reputation within the community. Participants indicated that where woman were perceived to be derelict in fulfilling this role, she may be at risk of social disapproval, often in the form of gossip. For example, Azadah (18 years old) said:

_They will think oh if everyone else in the community finds out, what will they say about me? [...] our family will have a bad image [...] the question is what will people say? [...] How will the community react to my condition, or to my health issues._

Expressing personal problems may be detrimental not only to a woman’s social status but also that of her husband and children. Participants reported not wishing to cause undue stress for their children, or not wanting to be a burden on other family members due to the stigma and social repercussions that may ensue from seeking help for their mental health concerns. In these accounts women’s identity is equated with that of the family’s – they are intricately linked. This may cause a woman to reconsider seeking help, as may risk reflecting poorly upon her family members, with Parisa (30 years) saying:

_Other people will not blame that girl, they will blame the family. [...] that’s the thing that stops people to go to any service or anywhere to help them._

As such, having a mental health issue and seeking help from a professional may be viewed as controversial within the community, as it would likely involve discussing family matters or marital issues. For fear of the social consequences, women may therefore choose to remain silent. For example, Parisa continued on to say:

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

**Cultural conceptualisations of mental health**

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

_Afghani people talk ‘if you go to the psychologist’ the Afghani people say ‘you are mad, you are crazy’ and maybe they can’t make friend with you [...] if my mother go there people said my mother is nuts or crazy and the meaning of crazy and mad in my culture is very bad. [...] the psychologists has very bad name in my culture (Rana, 20 years)._
You know in my country some people are going to mental health they say oh this is crazy because mental health is just for crazy people and their brain is not working (Qamar, 31 years).

Beliefs about mental health are predisposing factors (Andersen, 1995), and as such, cultural conceptualisations of mental health (and mental illness) as “mad[ness]” or “crazy[ness]” are likely to lead to low levels of help-seeking.

While younger women reported that mental illness was seen in a negative light in their community as presented above, they noted that views on mental health within their generation were gradually changing. This was predominantly due to younger women in the community growing up in Australia, being aware of available services, and receiving education about mental health, as well as forming support networks within the broader Australian population. Azadah (18 years) said:

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

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

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

These reports are consistent with previous literature that highlight the frequency of refugee women in general (Kastrup, 2006), and specifically Afghan women resettled in Australia (Rintoul, 2010), presenting with emotional distress that manifests as non-specific somatic complaints such as headaches and pain. However, women in the current study also noted that these physical complaints were conceptualized by some within the Hazara community as contagious, and that those who physically exhibited symptoms may therefore be further isolated, as Lila (18 years) explained:

They think like if this person has a mental health tomorrow I will I get in the same situation, [...] like I get mental health tomorrow, so they think like that. Sort of like flu you know.

Overall, then, participants’ accounts in interviews supported Andersen’s (1995) stated predisposing factors in relation to help-seeking, highlighting that negative conceptualizations of mental health and illness related to culture are likely to inhibit help-seeking for individual women, who may feel stigmatization were she to seek help, particularly professional help.

**Domestic Violence**

Participants in the study noted that the violence towards women that occurred in Afghanistan was a significant factor that predicted mental health issues for many women community members. Importantly, domestic violence (or violence more generally) was not explicitly asked about in interview questions; however, violence was often brought up spontaneously by participants when asked what the most significant issues for women were, or what would stop
a woman from seeking help, as seen in the extract from Saba (21 years) below, in response to a question about causes of any mental health issues Hazara women face:

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

Previous research indicates that gender-based violence is not uncommon in Afghanistan, with studies with women in shelters in Kabul identifying experiences such as subjection to violence when attempting to leave abusive relationships, inability to leave the house without supervision from men, forced virginity exams, and threats of honour killing (Stokes, Seritan & Miller, 2016). Many of the accounts of women in the current study also point to the cultural differences and changes in gender roles that women experienced in Australia. For example, Saba continued on to say:

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

Nevertheless, participants did recount experiences of domestic violence in their community in Australia. These experiences and the associated mental health issues were spoken about as something that many women were expected to endure, and remain silent about:

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

Related to the earlier sub-theme of stigma in relation to mental health issues, participants highlighted that seeking help for domestic violence also remained highly stigmatized, and would attract significant opprobrium from the community, as further noted by Parisa below:

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

Husbands often act as gatekeepers
In addition to threats posed by domestic violence, husbands were often perceived more generally as potential barriers to help-seeking. Participants mentioned that a spouse would most likely perceive a woman seeking help for mental health concerns as a negative reflection upon them, their relationship, or their family life.
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Their partner – unless there has been problem they don’t appreciate them to go share, because they would definitely stop them. The partner would think if you share that they have this problem and it may look probably unusual for others because they think your woman’s crazy […] think you would be a joke. (Mahlia, 32 years).

Importantly, there were differences in the way that participants discussed the issue of husbands as barriers or gatekeepers to services, which were based upon the age of both the participant and the men they were discussing:

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

In general, then, participants highlighted that older men were more likely to impede help seeking for women than younger men. Andersen’s model has been used to predict help-seeking for family and domestic violence (e.g., Fleming & Resick, 2017), however this study points to the possibility for extension of Andersen’s model to consider family and domestic violence – and indeed in some instances the role of intimate relationships themselves - as pre-disposing factors.

Language and Communication

As previous studies with refugee communities have illustrated (Colucci, Minas, Szwarc, Paxton, & Guerra, 2012; Colucci, Minas, Szwarc, Guerra & Paxton, 2015; Sheikh-Mohammed, MacIntyre, Wood, Leask, & Isaacs, 2006) lack of English language proficiency remains an enduring barrier to help-seeking for mental health services. Notably, in this study there appeared to be a paradoxical challenge for women with no English skills in relation to help seeking. That is, while women were required to attend English classes, mental distress restricted their ability to learn English, which in turn limited their ability to seek help for mental health. Notably, the two older women in the study reported having headaches, thinking about traumatic past experiences, worrying about separated family members, and finding it difficult to concentrate during English classes. Both women dropped out of classes within one year and stated that they had not attempted to learn English again.

When I talk to them they say we can’t learn at this age, and then I say you can! […] But they are negative, they said we can’t. And I guess they cannot because their minds are not here. [...]See my mum is here, her mum is there, she thinks about her. [...] She thinks about her past. She thinks, what is happening there? (Laila, 18 years on behalf of her mother, Jamilah, 59 years).

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

These findings align with those of another study with Iraqi refugees in Australia (Slewa-Younan et al. 2015), which highlighted the impact that psychological distress may have on refugees enrolled in English language classes. The predisposing factors of ethnicity, in this case Afghan (Hazara) and English language skills were both pre-disposing barriers to mental health service use (Andersen, 1995). In participants’ examples here, their low levels of English and
lack of ability to engage in English language classes compounded their ability, opportunity and subsequent decision to access mental health services.

**Informal help-seeking preferences**

Aligning with the aforementioned literature (Fleury, Grenier, Bamvita, Perreault & Caron, 2012; Lasebikan et al., 2012; Pescosolido et al. 1998; Maulik, Eaton, & Bradshaw, 2009), participants in the current study reported a preference for relying on various informal support options rather than seeking professional services. This included particularly their existing social supports and – particularly for older women – religion). In relation to social support, women reported that discussing shared experiences including being separated from family members would relieve some emotional distress, as Rana (20 years) said:

*They find their friend or woman like herself and talk together and remove the bad events in their mind or anything that bad effect in their memory.*

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

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

Religion was also reported as an informal help-seeking preference. There is research showing that religious belief can encourage an internal locus of control (associated with well-being), and may have positive effects such as enhancing acceptance and resilience (Behere, Das, Yadav, & Behere, 2013). This aligns with reports from women in this study, where religion was mentioned as a coping strategy - particularly for older women:

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

On the other hand, younger participants who had grown up in Australia questioned the effectiveness of turning to religion for support with mental health. For example, whilst Azadah reported above that her mother drew strength from religion, she felt that “talk[ing] to someone” was also important:

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

Andersen's (1995) model includes social support and religion as pre-disposing factors for help-seeking, and in this study they mostly appeared to act as barriers. However, it is important to note that their effectiveness and value is not to be dismissed. Aligning with previous research with refugee populations regarding resilience and coping strategies, women drew strength and positivity from their social connections within the community (Correa-Velez & Gifford & Barnett, 2010; Schweitzer, Melville, Steel & Lacherez, 2006) and their strong faith in their religious beliefs (Schweitzer, Greenslade, & Kagee, 2007; Khawaja et al., 2008; Sossou, Craig, Ogren & Schnak, 2008; Lusk, Terrazas, Caro, Chaparro & Antunez, 2019).
Discussion and Recommendations

The result of this study suggested that interconnected, complex social and cultural barriers to help-seeking exist in varying degrees dependent upon predisposing (Andersen, 1995) and demographic factors for women from the Hazara refugee community in Australia. Overall, Andersen’s (1995) model appeared to be useful in relation to predicting help-seeking, with age in particular identified as a pre-disposing factor, together with stigma, cultural conceptualizations of mental health, social support, religion, and English language proficiency. However, this study also found that the women discussed high levels of domestic violence, including husbands acting as gatekeepers to help-seeking, which extends understandings of Andersen’s model for use with the Hazara refugee community. Here, we discuss these findings and outline recommendations for best-practice.

Notably, participants’ age seemed to influence reported experiences and perceptions throughout every theme. Older women were reported to be most disadvantaged in terms of service access, due to the increased likelihood that they face barriers such as low levels of English, isolation, stigma surrounding mental illness and domestic violence, and restrictive gender roles. A potential explanation for this is that age could be acting here as a proxy for education levels, whereby younger participants – like those from many cultural backgrounds – may be more aware of mental health and illness. There is less research with older women from refugee backgrounds from other age groups – and in this study accounts were often from younger women recounting their mothers’ or other women’s experiences. There are contradictory reports about age and its influence on help-seeking in Afghan culture more broadly (Slewa-Younan, Riosco, Guajardo, & Mond, 2019) and thus this is an important area for future research.

Although domestic violence is a phenomenon in all cultural and faith groups (Devries et al., 2013), in this cultural context, due to the reported high levels of stigma, domestic violence issues appeared to be a key restraint to women’s help-seeking for both domestic violence support and mental health concerns. Previous research indicates that there are complex intersecting factors associated with domestic violence for people from refugee backgrounds that may inhibit help-seeking including migration pathways, traumatic pre-arrival experiences, social isolation and resettlement stressors (El-Murr, 2018). More generally, previous research has suggested that women from culturally and linguistically diverse backgrounds (CALD) face inter-linked and overlapping barriers to access support for experiences of domestic violence including limited knowledge of rights/services, lack of cultural safety in those services, and family and community factors such as those noted above (Ghafournia, 2011; Harris, 2018; Vaughan et al., 2016). It is important for family and domestic violence – and the role of some husbands – to be recognized as a pre-disposing factor for help-seeking for mental health for women in this community. Moreover, it is important for service providers in this area not only to understand the general barriers to service access for this population but also that women from refugee backgrounds may be affected by experiences of domestic violence in different ways that subsequently influence help-seeking strategies (El-Murr, 2018).

The study also echoed findings of previous research pointing to various cultural understandings of mental health – including somatization or explanations of mental health in physical terms – as a potential barrier to help-seeking for women. Importantly, such differences in cultural understandings of mental health risk being interpreted as low mental health literacy, and therefore interventions may focus on education concerning mental health. However, Western notions of mental illness may make little sense in the context of the lives of many women with refugee backgrounds from Afghanistan, particularly older women. Nadeau and Measham (2006) suggest that that working with clients, family members, and cultural brokers
to develop a shared understanding of mental health and wellbeing is therefore necessary. The results of this study further support these recommendations and highlight the need for service providers to understand the unique cultural ways in which individuals think about and prioritize mental health concerns in their lives. This may be particularly important for General Practitioners (GPs) who are the front-line services that most women will initially engage with. If GPs are not adequately aware of how women may discuss mental health, they may not make appropriate referrals to mental health support (Due, Green & Ziersch, 2020).

Utilising social support networks was a preferred strategy to seeking professional help from services, aligning with previous literature reporting that higher levels of social support are often correlated with lower service use for mental health services – although this may be because people are adequately supported rather than support being a barrier per se (Faccincani, et al. 1990; Fleury et al. 2012; Lasebikan et al., 2012; Pesosolido et al. 1998; Maulik, Eaton, & Bradshaw, 2009; Sherbourne, 1988). For women in the current study, social support may include coping and healing strategies that are deemed ‘informal’ within Western psychological settings, but which could operate as formal healing practices within communities. Previous studies have recommended developing community-based mental health services that work to maintain and enhance the protective effect of individuals’ social support network (Faccincani et al. 1990). The social support networks that women reported using spoke the same language and often shared a collective experience of seeking refuge. If women more easily trust and relate to people of their own culture, then training community members as mental health professionals would ensure that Afghan – and particularly Hazara - women have the option of choosing services that are more culturally appropriate and that they may feel more comfortable attending, with less attached stigma.

Given the barriers that many women reported regarding language and communication, it is likely that outreach English language classes and mental health support may be more effective than the current model in Australia. Necessarily, these services would require teams of teachers, bi-cultural workers, mental health workers, and interpreters with appropriate, culturally responsive, training. Importantly, English language classes could be an avenue for teaching women about helpful services for mental health and domestic violence support. Women-only, group sessions for education and therapy may be more effective in this regard, given the collectivist culture and frequent gender-segregated practices of much of the Hazara community (Gondek et al., 2015; Felsman, 2016). Similarly, given the fact that the Muslim faith was portrayed as being highly significant in many participants’ lives, there may be an opportunity to incorporate mental health literacy into religious practices or Khutbahs (Islamic sermons) to draw attention to, educate about, and reduce stigma surrounding help-seeking for mental health services.

While this study has provided important information concerning mental health and help-seeking for women with refugee backgrounds from the Hazara community, it is not without its limitations. A small sample size and snowball sampling within a tight-knit community means that results may not be generalizable. Instead, these findings should serve as a basis for future research, particularly concerning family and domestic violence. The use of family members as translators may also be problematic. Although we chose to respect participants’ preferences for family interpreters, this may have meant that they felt uncomfortable to discuss certain topics. For future projects of this type a research team, including bi-cultural workers and interpreters, is required to ensure that the voices of those who do not speak English are included. Indeed, as this research suggests, older Hazara women with no/low English proficiency may be those with the greatest unmet needs.
Conclusion

This study highlights the importance of understanding the unique situation of the lives of many women from refugee backgrounds, both from a theoretical and applied standpoint. The study points to a range of barriers to mental health help-seeking, including differences in ways of conceptualising mental illness, husbands acting as gate keepers, and stigma surrounding mental health. The study also points to the complex interactions of what are considered pre-disposing variables (Andersen, 1995), including the ways in which social support and religion may act as barriers to access to professional services, while also offering protection from mental illness. Importantly, young women in the study expressed concern that their mothers and grandmothers did require further support.

In relation to family and domestic violence specifically, the National Plan to Reduce Violence against Women and their Children (Commonwealth of Australia, 2016) and the Intimate Partner Violence in Australian Refugee Communities review (El-Murr, 2018) highlight the issue of domestic violence in CALD communities and the importance of early intervention and for services to practice in a culturally safe manner. Considering this, as well as the findings of the current study, it may be necessary for women from this group presenting with mental health issues to any service to always be assessed for family conflict or domestic violence. In general, however, the study points to the need for training and resources to reach out to women who may be isolated to offer support and assistance that is culturally safe and responsive to their own living situations, beliefs, and past experiences.

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Address for Correspondence
Clemence Due: clemence.due@adelaide.edu.au

Author Biographies

Rose Burford-Rice is a registered psychologist currently working in the field of child protection. Her research interests include prejudice and racism, and the mental health and wellbeing of people with refugee and migrant backgrounds. She is also interested in discourse and social psychology, cross-cultural psychology, and using participatory research methodologies.

Clemence Due is a senior lecturer in the School of Psychology at The University of Adelaide, with expertise in the area of cross cultural psychology and particularly mental health and wellbeing for people with migrant and refugee backgrounds. She is also interested in trauma, grief and loss, including following stillbirth or neonatal death. Clemence is on the management committee for the Fay Gale Centre for Research on Gender.

Martha Augoustinos is a Professor in the School of Psychology at The University of Adelaide. Her expertise lies in the areas of social psychology and particularly race, gender, prejudice, social identity and social exclusion, including in relation to people with refugee and migrant backgrounds. Over the past 20 years she has made significant advancements to social psychological theorisation, particularly in relation to understandings of attitudes and prejudice.