Immigrant Mental Health and Healthcare Access

An In-Depth Analysis of the Lived Experiences of Immigrants Within a Local and Global Context

MIRA KLEIN

A CAPSTONE ESSAY SUBMITTED IN PARTIAL FULFILLMENT TO OBTAIN A MASTERS DEGREE IN POLICY STUDIES

THE UNIVERSITY OF WASHINGTON
AUGUST 2022
ADVISOR: DR. SHAUNA CARLISLE

Abstract

With the rise of mental health crises in concurrence with the COVID-19 pandemic, as well as global catastrophes that people around the world have experienced as a result of war, climate change, and a variety of other occurrences, the subject of immigrant and refugee mental health is more pertinent than ever. This capstone project seeks to explore the lived experiences of refugees and immigrants and analyze the relationship between being a member of these demographics and experiencing negative mental health outcomes. The literature review present in this writing indicates that while there are higher rates of psychopathology among refugees and immigrants, and even more so for asylum seekers, the specific type is somewhat dependent on demographic origin. The conclusion from the combined research from the literature review and the own personal research indicates that psychopathology is indiscriminate of national origin. Likewise, immigrants and refugees are at an increased risk for developing conditions such as depression and anxiety disorders. Regardless, it is important that careful analysis of refugee and immigrant mental health continues, so as to provide better mental healthcare for these populations in their new host countries. This capstone also presents a unique lens into refugee and immigrant narratives, as research participants who were present in this study shared their experiences anonymously.

Table of contents:

CHAPTER 1: INTRODUCTION 5

CHAPTER 2: Review of Literature 8

Lack of Housing and Employment for Immigrants and Refugees Results in Stress: 9

Immigrants, Refugees and Mental Health Risk Factors: 12

Substance Abuse Among Immigrants and Refugees: 14

Common Disorders Among Immigrants and Refugees: 16

Religion As a Mental Health Buffer: 19

Asylum Seekers and Mental Health Comorbidity: 22

Mental Health Stigma and Cultural Barriers to Seeking Help: 28

Suicide as a Consequence of Mental Healthcare Negligance: 30

Funding for Mental Healthcare for Immigrants and Refugees: 31

The Importance of Narratives and the Historical Struggle to Obtain Them: 32

Conclusion and Gaps in Literature: 33

CHAPTER 3: METHODOLOGY 35

Methods: 35

Design and Materials: 35

Measures: 37

Data Source: 38

Procedures: 38

Ethical Considerations: 38

Limitations: 39

CHAPTER 4: RESULTS 41

Demographic Results 41

Main Study Results 42

Crosstab with Chi-Square results: 43

Discussion: 44

Results of Qualitative Responses: 44

CHAPTER 5: RECOMMENDATIONS **58**

References 51

Appendix A 53

Demographic results of participants 53

Table A1 53

Table A2 54

Table A3 55

Appendix B 57

Main Study Results 58

Table B1 58

Table B2 59

Table B3 59

Table B4 60

Table B5 60

Table B6 62

Table B7 62

Table B8 63

Table B9 64

Appendix C 65

Chi-Square test results 65

Table C1 65

Table C2 67

Table C3 68

Table C4 70

Table C5 72

Table C6 73

Table C7 75

Table C8 78

Table C9 80

Table C10 82

CHAPTER 1: INTRODUCTION

The United Nations High Commission for Refugees (UNHCR) announced that displacement numbers around the world reached an all-time high in 2020, with over 80 million people being displaced from their homes globally (Monin, et al, 2021). Of that, over 20 million were designated as refugees, and over 45 million were legally classified as being internally displaced peoples (refugees within their own country). The United States has experienced fluctuations regarding the number of refugees, asylum seekers, and immigrants it receives. Under former President Trump, the number of refugees who would be allowed to resettle in America reached a shocking low, at less than 16,000 people per year (Monin, et al, 2021). Current president Joe Biden has allowed this number to increase significantly, by up to nearly 63,000 people a year, according to the official white house website, but the problem remains steadfast (Source: The White House Briefing Room, May 3rd, 2021).

For immigrants and especially for refugees, the resettlement process is often an extraordinarily daunting and taxing experience. Such significant life disruptions can result in serious mental health psychopathological outcomes, such as post-traumatic-stress-disorder (PTSD), anxiety, depression, and other conditions that often require treatment. (Good, 1996). This signals an important question: Do refugees and immigrants face higher levels of psychopathology compared to their non-refugee/immigrant counterparts? These questions are important, and this writing seeks answers from both local and global contexts. This writing also documents the lived experiences of immigrants and refugees who have relocated to the greater Seattle area, as a variety of individuals who were present in this research, wrote about their experiences. For safety reasons, questions pertaining to asylum status were not asked on the

survey that will be presented later in this writing. However, asylum seekers will be included within the demographic population in this research.

The current research allows for vital analysis on a variety of issues that greatly affect the mental health of refugees and immigrants. For example, research has shown that mental health disorders, especially mood disorders, and PTSD, are quite common for Syrians who have survived the Syrian civil war (Sims, p.42, Hassan, p.2). The current research also provides insight on the effect that mental health stigma has on individuals seeking professional help. Research has provided data that suggests that mental health stigma is so bad, that it prevents people from seeking out care (Corrigan, et al., p.37). This is true to the extent that even when one's mental health condition is so dire that it becomes disabling, seeking out care is simply not seen as a viable option (Corrigan, et al., p.39-40). The current research provides data on another troubling aspect of mental healthcare: Chronic and severe underfunding of mental healthcare (Corrigan, et al., p.57). The current research provides reasons why this underfunding is such a problem, and how it has managed to persist for so long, despite evidence that more resources must be allocated on mental healthcare. While there is an impressive amalgamation of literature on refugee and immigrant mental health in a global and international context, there is a noticeable lack of data that is available in a domestic, and local context.

Scientists, doctors, and professionals have conducted extensive research on a variety of subjects that pertain to the mental health and healthcare access of the greater immigrant community. Personal narratives, however, are noticeably absent from the studies. Likewise, there is a shortage of information regarding local, national, and international health budgets that go towards mental healthcare. This writing seeks to provide more personal narratives, as well as

provide local data that will be collected and used to provide suggestions for policy change regarding immigrant mental health and healthcare access.

For full disclosure, the head researcher of this capstone project has personal experience as an immigrant and that has heavily impacted the scope of this research. The head researcher is fully aware of the importance of narratives, and that comes from those with lived experiences. Mental health is both underfunded and under researched. Despite this gap between what the research points to and resources allocated to it, health is comprehensive and includes mental health as much as it does physical health.

CHAPTER 2: REVIEW OF LITERATURE

With the plethora of historical domestic and international catastrophes that have forced people to flee from their homes, as well as the current Ukraine crisis that has caused over 7 million people (as of this writing) to be displaced both internally and externally, the refugee crisis only seems to be mounting (The White House Briefing Room, May 3rd, 2021).

When one thinks of refugee and immigrant populations, one might contemplate food, housing, moving around, learning a new language, etc. There is another, albeit much darker, aspect to being a member of these demographics: The increased risk of developing various psychopathological conditions, such as anxiety and depression disorders. Even if one openly acknowledges this reality, the extent that mental health is taboo across cultures and societies worldwide, makes recognition a challenge. Treatment even more so. This literature review seeks to amalgamate literary information that is available on the mental health of refugees and immigrants from around the world. Furthermore, this writing seeks to identify what *hasn't* been analyzed and explain that these gaps in knowledge must be addressed through further research (this will be presented later in this writing). The following themes will be explored throughout this literature review: The mental health consequences that result from being uprooted from one's home; The struggle to find employment and the stress that is associated with lack of employment; the mental health consequences that one experiences when one cannot access housing; asylum seekers and the effect that detention has on mental health; the role of religion and its potential to act as a barrier to negative psychopathology; racism and the unique challenges that immigrants of color must face when they move to a new country; common disorders among the refugee, asylum seeker, and immigrant populations; Suicide as a result of

various psychopathological conditions; mental health stigma; emotional wellness and being a survivor of trauma; Funding for mental healthcare for refugees and immigrants.

*Note: There is significant overlap between these themes throughout this writing, and these themes are not perfectly demarcated between one another.

Lack of Housing and Employment for Immigrants and Refugees Results in Stress:

If one comes from an immigrant or refugee background, narratives of the hardship and strife that are associated with leaving the ancestral homeland, are common. However, what is seldom articulated in these narratives is the extent of the hardship and the potentially dire mental health consequences that went alongside the people as they left their homes and resettled in new and foreign territory. The Syrian civil war provides an illustrious example of the mental health challenges that displaced peoples often experience.

Ahmed Hassan examines the mental health crisis that has gone mostly unmentioned, as a consequence of the Syrian civil war. His writing concentrates on the psychopathology of Syrian refugees, with a special interest on mood disorders and PTSD. The following explains why these two disorders are of particular concern for those who have experienced being uprooted from their home.

As of 2019, more than 6 million Syrian refugees have become displaced, internally, and externally (Hassan, p.1). Hassan points out that an entire generation of Syrians have existed only within the context of the war and have never experienced anything else. This generation of Syrians have sometimes been macably referred to as “the lost Syrians” (p.1). Within a year of the civil war starting, the UNHCR counted over 30,000 Syrians, who (at the time), had recently become refugees with most of these people living abroad in refugee camps (p.1). The living conditions for these refugees could accurately be described as sordid. Being forcefully uprooted

poses a unique threat to one's mental health, due to the heightened risk of developing serious mental health disorders (p.2). In the context of the Syrian refugee crisis, for example, the UNHCR came out with a study that identified the most common mental health disorders among Syrians, were prolonged grief disorder, anxiety disorders, PTSD, and depression (p.2). PTSD and depression were observed at especially high rates among Syrian refugees (p.2). Another study presented data that concluded that 54% of Syrian refugees had severe emotional disorders and almost 27% of minors who were part of the study, presented both intellectual and developmental problems (p.2). These conditions can result in life-long consequences.

Byron J, Good is an anthropologist who specializes in mental health research and is the author of "Mental Health Consequences of Displacement and Resettlement." Good emphasizes that there is very little explicit attention paid to the mental health of refugees and immigrants (Good, p.1504). Ironically, it's common knowledge that resettlement poses significant mental health challenges (p.1504). Good states that with little exception, displaced people deal with profound consequences that are often inter-generational (a concept commonly known as intergenerational trauma) (p.1505). Two of the most significant risks of experiencing displacement are economic, and personal exploitation (human smuggling across borders for an exorbitant fee or being enslaved in human trafficking rings) (p. 1505). If one or both are manifested, one is consequently left without a sense of self, financial security, or safety. The mental health costs of such an experience can be insurmountable.

The World Mental Health Report provides critical data as to why it's important to keep a close eye on the mental welfare of refugee and immigrant populations. The report presented data that suggested that mental health issues are often clustered, and often exist within an oppressive context (p.1505). For example, if one experienced violence at the hands of human traffickers,

one would be at high risk for developing mental health disorders such as PTSD. Good provides a poignant example of some of the direst consequences of being uprooted from one's home, with an analysis of the history of the Indigenous people of Turtle Island (modern day United States). Boarding schools, drug and alcohol abuse, physical abuse…the list of traumatic experiences forced upon the Indigenous people of Turtle Island is endless (p.1505). Good emphasizes that forced resettlement is such an awful experience, that it should be avoided at nearly all costs, and only used as a truly last-resort option (p.1506). Additionally, unemployment, which is not an uncommon experience for refugees and immigrants alike, has been recognized as being a high-risk factor for developing a variety of psychopathological conditions (p.1506).

Erwin Zareie narrated his own experience as a homeless refugee in the anthology "while the earth sleeps, we travel.," written by Ahmed Badr. Zareie exclaimed: *"But when I first arrived, I was one of the homeless people. I had no money. I had nowhere to go. My English was really poor and I slept in Victoria Park for almost a month."* (Badr, p.10). The desperation and stress in his statement is tangible.

Byron J. Good provides an excellent summative statement on the refugee and immigrant experience. He writes that with adaptation, there is grief (p.1506). This is noteworthy because adaptation is a key part of the immigrant and refugee experience, every single person who is part of that demographic will experience it to some degree. Grief of any kind is an extremely disrupting experience and can cause great psychological damage if it gets out of control or is prolonged. Good notes that for elderly immigrants, depression may present itself as dementia (p.1507). There is compelling research that shows that having the financial means to seek treatment for these conditions may put one at an advantage for positive mental health outcomes, compared to one's poorer counterparts.

Are financial safety nets cardinal for one's mental health? The data varies, but according to Bukola Salami, et al., yes. The authors write that being unemployed increases the risks of developing mental health conditions. Being unemployed means a predictably lower financial status compared to one's employed counterparts. Immigrants and refugees often struggle with this, making the potential for developing a mental health condition all the greater. (Salami, et al., p. 365). The authors also point out that those who are older are less likely to deal with mental health issues when they resettle, unlike youth, who are at greater risk for developing mental health conditions, due to a variety of factors, such as experiencing a massive life disruption at a young age (p.365).

Good, Badr and Salami, make important contributions to the conversation and research, regarding not only mental health for refugee and immigrant populations, but provide powerful and well-sourced material on the subject.

Immigrants, Refugees and Mental Health Risk Factors:

An individual will be presented with various challenges as an immigrant, both mental and physical. Overcoming these challenges can be an arduous task. According to Awad, et al., authors of "Trauma and Racial Minority Immigrants," many immigrants experience distress over fears for the well-being of family members back in their home countries (Awad, et al., p.230). This fear is not isolated in accordance with demography, as signs of distress have been clear from news reports on the recent Ukraine invasion and war (as of 2022). However, being an immigrant of color presents unique challenges that will not be experienced by a white immigrant (Awad, et al., p.229). Regarding mental health, there is an especially attentive analysis on the unique traumas that people of color are more likely to face compared to their white counterparts.

This following section will focus heavily on the experiences of BIPOC (Black, Indigenous, People of Color) immigrants, and the unique threats that challenge their mental health.

There are three primary sources of racial and ethnic cumulative trauma: historical trauma, national context, and institutional discrimination (p.229). Sometimes, immigrants will encounter dire situations that will pose a direct threat to their overall wellbeing and mental health status. Violence, malnutrition, familial separation, poverty, etc. Many of these problems are strongly correlated to geography. Immigrants from the MENA (Middle East and North Africa) region, for example, reported fleeing persecution or violence, due to discrimination, and it is possible that they either experienced, or were direct witnesses to, torture and/or political oppression (p.230).

Immigrants of color who arrive in the United States, may, as Awad, et al., explain, be forced to come vis-a-vis with racism for the first time in their lives. This is worthy of analysis since it can have grave mental health implications (p.230). Despite this terrible experience, coping mechanisms have been shown to be a key factor in preserving one's mental health in the face of adversity. However, there is no single way to be resilient. Awad, et al., explain the tentative nature of resilience: "There are several definitions of resilience. For example, scholars in the field of human development define resilience as the capacity to endure or effectively cope with hardship (Ledesma, 2014; Wener & Smith, 2001). Other definitions focus on the extent to which an individual can recover from unfavorable life events and gain strength from experiencing adversity (Henderson & Milstein, 1996)" (p.253).

There is promising research showing a positive correlation between having a strong connection to one's ethnic background, and that relationship serving as a buffer from hateful messages that would otherwise likely become internalized (p.234). For minorities, this is a key factor in maintaining a positive and healthy mental health structure. For people of color, ties to

one's ethnic and cultural roots are especially important. Research that analyzed over 180 studies, conclusively and unanimously showed that having a stronger ethnic identity resulted in greater well-being for people of color in North America (Smith & Silva, 2011), (p.235).

Substance Abuse Among Immigrants and Refugees:

Access to mental healthcare can be challenging for state residents and citizens. If one is classified as an immigrant or refugee however, one may become desperate enough to turn to substance abuse as a coping mechanism, due to lack of healthcare access. If certain disorders go untreated, individuals are more likely to self-medicate (often by means of illicit drug and alcohol use) as a result.

Michael Brune, et al., authors of "Treatment of Drug Addiction in Traumatised Refugees," explore the relationship between PTSD and consequential substance abuse in refugee populations. A cardinal reason why self-medication is a relatively prominent coping mechanism among refugees who suffer from PTSD, is because there are a variety of barriers, including social, cultural, and financial, that make seeking out professional care from a specialist, quite difficult (Brune, et al., p.144). Professional care and healthcare access are not always readily available, even for those who require it in a timely manner.

A primary risk factor in extended drug abuse among PTSD survivors, is the likelihood of getting the drug addiction treated, while simultaneously neglecting to seek out care for the PTSD (p.144). This is treating the symptom without addressing the cause. Failing to address PTSD (if it is indeed a relevant part of the comprehensive history of the patient) is a negligible solution at best, and an outright dangerous one at worst, because this increases the likelihood for substance abuse relapse.

Brune, et al., provide a powerful anecdote, pertaining to PTSD survivors and consequential self-medication. Mr. M., (a pseudonym), fled to Sweden, from Iran. In his home country, he had been tortured and once he was released, he found respite in medically perscribed benzodiazepines. For months on end, he suffered from nightmares, flashbacks, severe irritability, and jumpiness. Taking the drugs seemed to take the edge off, and he eventually became dependent on them to be even remotely functionable. Sometime before he sought therapy and professional help, he ditched the Benzodiazepines for Heroin, because, according to him, it “worked better" (p.145). This narrative, while deeply troubling, is not uncommon. Drugs release chemicals in the brain that can allow PTSD symptoms to be temporarily relieved or lessened (p.145). Therefore, substance abuse among PTSD survivors is a serious concern for mental health professionals and survivors alike. PTSD (or other mental disorders) must be treated concurrently alongside drug addiction, or else treatment is “condemned to fail” (p.146).

The “Addiction center” website addresses substance abuse in immigrant and refugee populations. The Addiction Center also provides key differences between the two groups that require analysis.

There are a variety of factors that can generate substance use as a coping mechanism; It is not required for one to be a refugee or immigrant for one to feel immense stress and emotional pain. Lack of housing, for example, can be a source of great distress, and sometimes drugs become the most readily available coping mechanism. Immigrants have more stability than refugees, regarding housing, but it doesn’t decrease the likelihood of substance abuse among immigrant populations (Addiction Center, 2022). There is one drug that is of primary concern, not only due to its wide availability (and legality in dozens of countries for those either 18+, or 21+, depending on where one resides), but due to its potentially lethal consequences of quitting

cold turkey (25% of all addicts who become reliant on this substance who try to quit cold turkey die from withdrawal symptoms): Alcohol.

Alcohol, unsurprisingly, is one of the most common substances that refugees abuse and become heavily dependent on, just to survive. When under immense amounts of stress, alcohol is often used as a form of self-medication, or as a coping mechanism. There have been statistical studies that provide data that suggests that refugees who are either/or/and male, a young adult, unmarried, are at the highest risk of becoming dependent on alcohol or developing what is known as "AUD" (alcohol use disorder). There is a demographic element to this. The Addiction Center shared survey results that showed that 36% of Burmese participants were using alcohol at a high rate, while 4% were noted as potentially becoming outright heavy alcoholics. The AUD rate for Ugandan refugees was at 32% for men, and 7% for women. Nepalese refugees had an AUD rate of 23% for men, and 9% for women. Having an alcohol dependence or disorder increases the likelihood of developing other serious mental health disorders, such as anxiety, depression, and even suicide (Addiction Center, 2022). This is just one type of comorbidity. Immigrants and refugees have not only standalone disorders that must be recognized, but the risk of experiencing comorbidity is equally deserving of recognition.

Common Disorders Among Immigrants and Refugees:

Mental health disorders among refugee and immigrant populations have been touched on throughout this writing but have yet to be analyzed in-depth. This following section is a cornerstone of this writing.

"Many Refugees Can't Flee Mental Ailments," by Bruce Bower, highlights the mental and physical health of torture survivors. It is not unusual for asylum seekers and refugees to have experienced torture in their home countries. This can be a result of politics, ethnic identity, or

something else entirely. The mental scars of torture can far outlast those of the physical manifestation, and this matter is worthy of analysis.

According to Bower, data shows that refugees who have experienced torture are more vulnerable to experiencing negative mental health outcomes. A study of Bhutanese refugees produced sobering data on the matter. This study focused on Bhutanese torture survivors and researchers discovered that that 16% of the sample population of Bhutanese refugees had experienced torture and a significant portion had been formally diagnosed with at least one mental disorder. These disorders often became visible only after the refugees had been legally classified as refugees. (The reason for this was not stated, but it can be hypothesized that this had to do with the label bringing about recognition of their experiences and forcing an end to any denial or repressed memories that they may have had).

Bower researched non-tortured refugee populations as well, and stated that according to available data, psychopathological conditions thrive among refugee populations regardless of torture status. Bower cited a study that concluded that nearly 50% of non-tortured Nepalese refugees had been diagnosed with a mental disorder once they had left Nepal (Bower, 2021).

The refugee experience cannot be reduced to enduring war. There is more than one type of war that refugees often must deal with. Mental warfare. Mental warfare is a popular method used against civilian populations in conflict settings. Raija-Leena Punamaki, author of “Political Violence and Mental Health” explains: “The aim of war is not only to defeat the opponent militarily but also to break down the morale of the civilian population on the enemy’s side” (Punamaki, p.3). This is not a coincidence, as Punamaki points out that mental health becomes heavily weaponized in conflict zones (p.3). Mental warfare leaves no physical scars, but it can be a lifelong process before one can heal from the psychological damage produced by it.

At times, adult refugees who experience trauma in conflict settings, experienced trauma during their youth. In other words, they are being re-traumatized. The likelihood of being a victim of childhood trauma is heavily dependent on demography, and the life-long psychopathological consequences can be harrowing. Historically, this can be illustrated quite clearly in the context of the Apartheid regime in South Africa. Punamaki explains that Black youngsters who were living under the brutal Apartheid regime took up the fight for their freedom and dignity, against their oppressors in a very literal sense. Consequently, these youth were often arrested, beaten, and tortured. These experiences, according to Punamaki, "may have had deteriorating effects on individual mental health" (p.6). Interestingly, not every conflict will result in the same trauma response, either in the immediate, or prolonged aftermath.

Punamaki cites a study that was conducted by Uriel Last that analyzed Holocaust survivors and the inter-generational trauma that is passed down to their descendants, and how it can manifest in "specific types of personality formation and family characteristics rather than in psychopathological symptoms" (p.10). Scientists have determined that Psychopathology is under-reported in trauma survivors, and statistics regarding the matter can be nebulous as a result.

Statistics regarding mental health disorders across refugee and immigrant populations are heavily dependent on demographics. Ryan Sims, author of "Into the Mind of the Refugee," explores the role that demographics have on psychopathology. Sims references an international study that concluded that in a refugee camp in Jordan, 21.6% of patients in the refugee camp had been given a diagnosis of an anxiety disorder, while 8.5% had been diagnosed with PTSD (Sims, p.46). With the current Ukraine crisis (as of the year 2022) more data must be collected in the future for proper cross-analysis.

"Findings from Mental Health Screening of Newly Arrived Refugees in Colorado," by Daniel Savin, et al., is based on a comprehensive health screening that was conducted in 1997, for newly arrived refugees. The screening covered both physical and mental health (this is noteworthy because mental health is rarely covered) (Savin, et al., p.224). 10% of all refugees who were screened, displayed some warning signs for mental health disorders and were offered referrals. 37% of these individuals followed through (p.224). The authors provide a list of some of the common mental health conditions that are often observed in refugee populations. These include but are not limited to: PTSD, depression, substance abuse, and Traumatic Brain Injuries (p.225). These disorders can be a result of a variety of traumatic experiences, such as exposure to violence, war, oppression, internment, displacement, and Sexual violence. Research has shown that mental disorders are particularly prominent in war-torn regions (p.228).

Religion As a Mental Health Buffer:

Mental and physical challenges have notable differences in experience and outcomes. Specifically, physical ailments can be somewhat relieved if one can use one's mind as an escape. However, there is no escape for mental ailments. One simply becomes a prisoner of one's mind. Research has shown, however, that there are certain buffers that can help prevent or postpone the onset of severe mental health conditions. Research has shown that religion and spirituality play cardinal roles in safeguarding one's mental health in times of great distress. Religion can be defined as; "Religiosity, or the degree to which a person adheres to and engages with a system of beliefs, rituals, and practices…" (Cervantes & Parham, 2055), (Awad, et al., p.235). With the variety of religious beliefs worldwide, this requires analysis.

An excerpt of the *Refugee Survey Quarterly,* contributed by Jean-Francois Mayer, examines the relationship between religion and mental health outcomes for refugee populations.

Notably, this relationship can change during different periods in the resettlement process (Mayer, p.6). Religion and religious affiliation, like water, are not stagnant.

For many, (especially for those coming from certain demographics which are more persecuted historically, such as Jews), religion plays a role in *becoming* a refugee. Remarkably religion may play a part in convincing people to leave, either willfully, or forcefully; "...religion is not absent from issues generating new waves of refugees and displaced persons" (p.6). Host countries however often have a hard time accurately determining when religious persecution is truly grounds for applying for asylum (p.9). One would think that if one became a refugee due to nothing else other than one's religious identity, that whatever religious ties exist would be consequently severed. Looking at the Holocaust as an illustrious example, survivors often fall into two categories: Having an extremely strong faith in God or being an atheist. A person who has been forcefully expelled from their homelands, undergone torture, and fallen victim to other unspeakable crimes, may view their experiences from a religious or spiritual lens. For some, it will be seen as a test from God. People who adhere to this mindset will often rely on their faith for guidance, when no other answers seem to be readily available (p.7). Sometimes this can lead to an overall stronger reliance on their faith.

Research has shown that refugees often become more religious after the resettlement process (p.7). The question is why? The answer is two-fold: The first is that religion can provide a vital connection to their ancestral practices and homeland. The second, is that religion can provide crucial stability for uprooted peoples that otherwise would be hard to find.

The connection that religion provides to one's ancestral homeland can be exhibited from a variety of religions. Refugees are not known to be thriving financially, but it is not uncommon for refugees to come together for their community and put their resources towards building

religious spaces, such as a church or a mosque: "Parishes are similarly like a piece of their homeland for Oriental Christians resettled in the West, places where they feel at home…Americans regrouping in France from the 1930s made it a priority to build churches as a way to maintain their collective memory and to express a collective identity to the citizens of the host country" (p.8). Not only do these places of worship provide a link for religious ties, but these places of worship provide a physical bond to one's identity (p.8). Occasionally, religious affiliation changes when one arrives to one's new host country, thereby changing the relationship to one's former community and one's past. Sometimes, people will convert when they arrive in a new country, and this is primarily done "as a migration strategy and as a sociocultural adaptation tool" (p.9). For instance, Iranian asylum seekers who fled to Turkey, converted from Islam to Christianity for this very reason (p.9). Will everyone from a religious background have the same experience if they are forced to become a refugee? No, and this is largely due to demography.

According to Awad, et al., authors of "Trauma and Racial Minority Immigrants," religion may have a stronger impact for people who belong to certain demographics. For communities who are from the Middle East and North Africa (MENA), religion can help when one is facing discrimination, or adversity (Awad, et al., p.235). There is research that suggests that religion can help one reaffirm one's own identity and can also help shrug off negative stereotypes about oneself and one's community. Research even suggests that religion can be effectively used as a coping mechanism against injustice and discrimination (p.236). There is narrative-based evidence for this. African migrants who were victims of domestic violence, narrated that having a strong personal relationship with God helped them have hope for their bleak living situations (p.236). For Mexican migrants, leaning into their strong belief system and recognizing control as

belonging to that of a higher power, positively impacted their well-being (p.236). Religion provides meaning to more than just the refugees themselves, however.

Many religious organizations throughout the world provide services that are specifically tailored for refugees. These organizations can be founded upon practicing the principles of love and humanity, which are principles that are found among many religions. Within the context of the United States, most of these organizations that seek to help refugees resettle are either Christian or Jewish (p.9). Regardless of what one's religious affiliation is, religion and spirituality can, and often do, provide much needed stability for refugees who are in the resettlement process (p.10). As discussed throughout this writing, stability in any form is critical for positive mental health outcomes for refugees and immigrants.

Trauma is a common experience for refugees, and the relationship between religion and certain psychopathological disorders (specifically depression and mood disorders) has been examined by researchers. Data suggests that higher religious rates are associated with lower rates of depression and mood disorders (p.235). For those who are asylum seekers, religion may provide an even bigger shield against the onset of mental health disorders; "Research has shown that communities facing traumatic circumstances use religion and spirituality to cope with distress. This is also true of incarcerated individuals serving long sentences" (p.235). For asylum seekers, this is of utmost importance.

Asylum Seekers and Mental Health Comorbidity:

The term "asylum seeker" can be slightly nebulous, as more than one definition exists and it can change depending on an international, or national context. For instance, the United Nations defines an asylum seeker as someone who: "seeks protection under the UN convention after

entering a country either on a temporary visa or without documents. The asylum process is an adversarial one in which the burden of proof lies with the applicant, and it can take years to reach an outcome. If the applicant receives a negative outcome, he or she can face deportation" (Ryan, et al., p.89). Authors Ryan, et al., provide a simple guideline for differentiating between refugees and asylum seekers. The authors share that unlike refugees, asylum seekers must live with the constant threat of deportation (p.88). This unique kind of stress, among other factors such as lack of employment, puts asylum seekers at high risk for developing a variety of mental health psychopathological conditions (p.88). In over 20 cited studies, with data collected from over 7,000 asylum seekers, researchers found that reports of psychological distress levels and mental health disorders were present at a much higher rate than average (p.88). This is particularly concerning due to the sheer number of people worldwide who classify themselves as asylum seekers, and/or are applying for asylum. In the year 2000, a total of 927,464 people worldwide applied for asylum status (p.89).

Asylum seekers are subjected to some of the lowest quality-of-life worldwide. They are often denied access to work, private accommodations, education, etc., (p.88). Asylum seekers are frequently rejected by society, and this is even true in western settings (p.89). This toxic mix of rejection, lack of personal freedom, little to no personal validation, and struggle to find work and be legitimized by a society that doesn't want them, puts asylum seekers in a vulnerable position for the onset of severe psychopathological disorders (p.89). Two Dutch studies that were cited by Ryan et al, found that mental health issues were more prevalent among asylum seekers, compared to refugees. In these studies, researchers found that asylum seekers had higher levels of depression, anxiety, and PTSD symptoms (62 percent, 41 percent, and 28 percent, respectively), compared to refugees (29 percent, 28 percent, and 11 percent, respectively)

(p.103). One study produced such alarming data that it demands further investigation; the study concluded that among asylum seekers, 96% of the sample population suffered from a depressive disorder of some kind, and 75.4% of those folks met the criteria for being diagnosed with major depression (p.98). Asylum seekers who have been detained by the state are at even greater risk for the onset of severe psychopathological disorders.

A study of 70 detained asylum seekers who were in the custody of the United States, produced data that showed that 86% of the sample population reported severe levels of depressive symptoms (p.90). Another study cited in this writing, conducted by Blackwell, Holden, and Tregoning, produced data that showed that out of a sample population of 397 asylum seekers, 18.9% reported depression symptoms (p.93). A third study conducted by Sourander, showed that 69% of asylum seekers who were participants, reported that they had depression (p.93). Depression is far from the only mental health disorder that asylum seekers may fall victim to.

PTSD and anxiety are two difficult psychopathological conditions that require various forms of treatment. Unfortunately, these conditions are found at a relatively high rate among asylum seekers. Ryan, et al., cite a study that concluded that out of the sample population, 24% of asylum seekers had PTSD (p.93). It is important to note that this number is relative and does not represent asylum seekers everywhere.

A variety of studies on PTSD have yielded a broad range of prevalence in sample populations, and this is heavily dependent on demographics. The lowest rate of PTSD is at 14% among Kurdish torture survivors, while the highest rates of PTSD have been detected among African Asylum seekers, with 82.1% meeting the criteria for being diagnosed with the disorder (p.99). Documented anxiety and stress levels among asylum seekers are no less concerning.

Ryan et al., cite a Dutch study that found that distress levels among the sample population of asylum seekers to be at 68.1%, and in the same study 37% of participants had experienced at least one very severe symptom within the week before the study was conducted (p.98). Likewise, a study by Hougan, et al., produced data that showed that 16.7% of Lebanese asylum seekers reported anxiety symptoms (p.99). Although anxiety and depression often have high comorbidity rates, these numbers are independent of depression rates.

Anxiety and distress levels among asylum seekers may not be due to the same reasons as depression among asylum seekers. Ryan et al., cite Silove et al., to provide reasoning for the former. According to Silove et al., the primary reason why asylum seekers experience such high levels of stress is because they run a significant risk of getting caught by authorities and consequently being sent back to their home countries (p.103). If that were to happen, imminent incarceration and/or death would be likely outcomes.

Asylum seekers who are attempting to flee to the United States are likely to encounter many hurdles along their journey. Authors Amy Shuman and Carol Bohmer explain in their writing "Representing Trauma: Political Asylum Narrative," that Asylum seekers must prove beyond reasonable doubt that they have a "well-founded fear of persecution in their homelands" (Shuman, Bohmer, p.394). This is quite difficult in practice. Asylum cannot be granted based on poverty or personal injury (p.395). In accordance with the guidelines outlined in article 14 of the United Nations convention, one can only be classified as an asylum seeker if one has a "well-founded fear of persecution for reasons of race, religion, nationality, membership, in a particular social group or political opinion" (p.395)." It is important to note that while there is a universal definition of what an asylum seeker is, this definition is surprisingly subjective on a cultural and demographic basis.

Bohmer and Shuman explain that within a demographic context, there is what is known as a “culture of asylum.” This refers to experiences that are often shared by refugees and asylum seekers worldwide. Every group and culture will have a different idea of what it means to be dignified, what it means to be a victim, and what persecution itself looks like. What one culture sees as persecution, may not be seen as persecution by another (p.402). Unfortunately, the issue of persecution does not seem to be decreasing. Especially not in the United States.

There was a noticeable uptick in anti-immigrant rhetoric preceding, during, and after the United States 2016 presidential election, primarily from people who were in positions of power. Then-president-elect Donald Trump was caught on camera saying that asylum seekers who came from south of the United-States border, were “rapists" and “criminals.” Unfortunately, asylum seekers have been forced to hear this rhetoric for years, and sometimes with violent outcomes. Venters, et al, analyze this issue in-depth in their writing, titled “Into the Abyss: Mortality and Morbidity Among Detained Immigrants.” Getting caught by ICE agents is just the beginning of asylum seeker related problems. The mental health consequences as a result of being caught can wreck lifelong havoc.

Immigration detention is the fastest growing form of incarceration in what is now the United States of America. Over 300,000 people are detained by ICE agents annually and there can be up to 30,000 people caught and detained at any one time (Venters, et al., p.475). Asylum seekers are under constant threat of being arrested by ICE, and once they are detained, their fate becomes nebulous, at best. The mental health care of asylum seekers who have been detained has been under scrutiny by advocacy groups and has been deemed as subpar (p.487). The mental health status of asylum seekers, however, has been subjected to limited studies.

Despite claims that ICE detainees are afforded top mental and physical health care, this claim is impossible to verify (p.476). A study that was conducted by both the NYU/Bellevue program for survivors of torture, and physicians for human rights, found (as of the year 2003), that, “the mental health of asylum seekers interviewed for this study was extremely poor and worsened the longer that individuals were in detention.” Depression, PTSD, and anxiety were especially prominent in detainee mental health evaluations and had observed rates of 86%, 50%, and 77% respectively, in the sample population. The study also produced data that suggested that the longer one was in detention, the worse their mental and physical health outcomes were (p.476). If one experiences torture at the hands of state officials while one is in detention, this is a logical, albeit cruel, outcome.

Detainees who are in state custody sometimes experience torture at the hands of the government. Drawing alarm is the use of segregation by ICE agents, as a means of punishment against detainees. Research suggests that such punitive forms of punishment lead to people rejecting any kind of professional help for treating mental health conditions (p.487). In the aforementioned 2003 study that was conducted by the Bellevue/NYU program for Survivors of Torture and Physicians for Human Rights, evidence was found that showed that detainees who had experienced torture at some point in their lives had developed mental health psychopathological conditions and were often forced into segregation as a result. This raised very serious ethical concerns because the detainees had often been victims of torture in their homelands and in those cases, isolation had been used as a form of torture and was now being used as a form of control by state agents. And even for detainees who were suicidal, mental healthcare access was deemed to be substandard at best (p.487). The greatest danger regarding suicide is that it has irreversible consequences.

Mental Health Stigma and Cultural Barriers to Seeking Help:

It is no secret that mental health stigma exists. Even in western countries, such as the United States or Canada, mental health stigma thrives. Patrick Corrigan, et al., analyze this issue in their writing, titled "The Impact of Mental Illness Stigma on Seeking and Participating in Mental Healthcare." Their research focuses on the impact that stigma has on mental healthcare. One of the first things that the authors emphasize is that a primary reason why people shy away from seeking help for mental health psychopathological conditions is due to the stigma that is attached to it. Epidemiological data points to a high number of people who need mental healthcare rejecting it, due to this very reason (Corrigan, et al., p.37). In fact, the stigma is so severe that it causes a lot of folks to stop treatment, even after they've already started it (p.37). For people who have psychopathological conditions that can be classified as "severe" this can be devastating.

The American Psychiatric Association (as of 2013) classifies psychopathological conditions considered as severe, to include the Schizophrenic spectrum, anxiety, affective disorders, personality disorders, and eating disorders (p.38). This classification is worthy of analysis, especially with the high rates of anxiety among the refugee population specifically. Scientists have acknowledged that severe mental illnesses can be so distressing that it can be completely disabling and destroy one's quality of life (p.39-40). In fact, two particularly concerning potential outcomes of severe mental illness are violence and suicide. These are irreversible if they are achieved, making them particularly threatening to one's well-being (p.38). Sometimes, even if one is actively experiencing a mental health crisis, one will be in denial about it and not admit to anything being wrong.

Sometimes people overestimate their own abilities, just to avoid professional help. For example, the National Comorbidity Survey produced data that showed that 45% of respondents who had a mental disorder refused treatment, because they thought they could handle it on their own (p.40). Stigma is largely responsible for this outcome.

Mental health stigma is particularly threatening for younger people. Mental illness is likely to hit them the hardest (the effects would often be stronger compared to their older counterparts), yet they are the least likely demographic to seek help (p.40). However, social stigma regarding mental healthcare does not discriminate in accordance with one's age (p.42). Data suggests that the problem of social stigma surrounding mental health is more significant than people may feel comfortable admitting to.

More than 100 peer-reviewed articles have pointed to high levels of stigma against mental illness and mental healthcare (p.42). However, the stereotypes surrounding mental illness will depend on what the illness is (p.42). For example, the stereotypes for anxiety and depression are that people who live with these conditions cry all the time, and those who have schizophrenia are all irredeemably violent and are an inherent danger to society (neither of these are true). The stereotypes surrounding more heavily stigmatized mental illnesses, such as schizophrenia are of particular concern to the people who live with these mental illnesses. With stigma often comes prejudice. Consequences of such prejudice include, but are not limited to: Social isolation, deeply rooted societal fear, lack of employment, and (shockingly) primary healthcare providers purposefully providing their mentally ill patients with substandard care (p.42-43). Stigma is both a systemic and personal issue, and for mental health care to be adequate, it must be thoroughly addressed. The more stigma is acknowledged and minimized, the more likely someone is to seek

help (p.44). So, what is the primary cause of all the stigma? According to Corrigan, et all., ignorance. Unfortunately, ignorance can lead to suicide if the situation is severe enough.

Suicide as a Consequence of Mental Healthcare Negligance:

As discussed throughout this writing, refugees and immigrants are at an increased risk of a variety of mental health conditions, including depression and anxiety. A potential outcome of the former is suicidal ideation, if not suicide outright. A Variety of studies have suggested a greater need for an increase in monitoring and tracking suicide ideation in order to prevent future suicides from occurring.

In 2012, the Centers for Disease Control published an extensive survey that contained information regarding suicide and suicide ideation amongst Bhutanese refugees who had resettled in the United States. The results of the survey showed that there was significant overlap between suicidal ideation and mental health disorders, such as anxiety, and PTSD. Likewise, there was a significant relationship between suicide ideation and issues that arose during/after resettlement, such as being unemployed or familial infighting (CDC, p. 533). Suicide rates among Bhutanese refugees who had been resettled were understandably cause for concern.

The Suicide rate among Bhutanese refugees who resettled in the United States was reported at 21.5 per 100,000, and the calculated rate when age was adjusted was 24.4 per 100,000. These numbers were higher in comparison to the annual global suicide rate and annual suicide rate in the United States, which, at the time of the study, stood at 16.0 persons per 100,000 and 12.4 persons, respectively. The Bhutanese suicide rate, however, was closer to the rate at which Bhutanese refugees who resided in refugee camps in Nepal, committed suicide, which was at 20.7 per 100,000 (p.533). This raises the question as to how prevalent mental health conditions were among the resettled Bhutanese refugees, and if there were warning signs,

and subsequent actions that could have been taken to prevent the suicides from occuring. Contrary to popular belief and (inaccurate) media portrayal, suicide does not always have warning signs.

The CDC study provided surprisingly low numbers for previously diagnosed mental health conditions for Bhutanese refugees who relocated to the United States, standing at a shockingly low 4%. This number changed, however, when researchers observed *present* issues. For present mental health issues, the numbers were alarming: 19% had anxiety, 21% had depression, and 17% showed signs of distress. These numbers did not reflect formal diagnoses, but perhaps should have been examined more thoroughly by a mental health professional (p.535). Funding for mental healthcare access however does not always make mental health professional access easy. Or even possible.

Funding for Mental Healthcare for Immigrants and Refugees:

Finances matter when it comes to mental healthcare. This is true both on a personal and systemic level. Corrigan, et al., write how people who are mentally ill are less likely to have health insurance compared to their neurotypical counterparts (p.49). If one lives in a country (such as the United States) where healthcare is not socialized, this becomes a very significant barrier. One can have the desire to seek help, but if one cannot get access to it due to financial means, it won't matter. Healthcare access and funding are truly matters of policy concern (p.57). Systemic underfunding, however, remains a significant obstacle.

Systemic underfunding, and lack of resources are significant barriers facing mental health services for refugees and immigrants. Ahmad Hassan cites German psychotherapist Dietrich Munz, who explained that even though there are about 4,000 psychotherapy sessions offered every year in refugee camps that are based in Germany, the need could be 20X higher (p.2). He

goes on to explain that only about 5% or so of the necessary healthcare is provided to refugees who are based in Lebanon, Syria, and Turkey (p.2). For Syrian refugees in particular, the data suggests a dire level of need.

Byron J. Good made an astounding statement regarding mental healthcare access: Policies that fail to address mental health care are incomplete policies (p.1504). Policies can be made on statistical evidence. But is it worthy to hear narratives from those who are in the greatest need of policy change? Yes.

The Importance of Narratives and the Historical Struggle to Obtain Them:

One can familiarize oneself with narratives. Being the narrator, however, is a unique position because not only can one connect with the reader on a personal level, but it secures the personal narrative for eternity. It prevents one's experiences and narrative from being permanently lost with time. There is a saying that one dies twice; The first is when one physically dies, and the second time is when one is forgotten. Sharing personal narratives allows for not only a better understanding of the world, but it prevents memories from being lost. This research included personal narratives for this exact reason.

Far too often, research participants are used to collect statistical data and are reduced to numbers and statistics, but rarely are they asked to share their stories. This is far easier said than done however, and the challenge to collect narratives can be demonstrated in the context of *Shoah,* (Holocaust), survivors and their testimonies to the world.

Michael Bernard-Donals, and Richard Glejzner researched Holocaust survivors, the importance of narratives, and the way in which survivors of genocide and immeasurable trauma process their experiences and share (or don't share) their narratives. Likewise, forgetting is just as present as remembering; "Absence is a structural part of witness…for we do not remember

trauma so much as we forget it–take it or leave it–in much the same way that the survivors in the Fortunoff archives do not so much recall their past selves in the present of the interviews but instead mark an absence in their narrative–of their lives, of their coherence as selves–that is only available as a (mis)remembered, a (mis)recognized history" (Bernald-Donals, Glejzner, p.8). Written and oral retelling are also different, as the authors explain; "Noting the differences between oral and written testimonies, Lawrence Langer tells us that, in listening to the former, 'we unearth a mosaic of evidence that constantly vanishes, like Thomas Mann's well of the past, into bottomless layers of incompletion" (p.17). Oral narratives, however, possess a unique element that is only present when speaking to one verbally, emotional presence.

The way in which Holocaust survivors share their narratives are just as important and noteworthy of analysis as the narratives themselves. Holocaust survivor Nathan A is a prime example; "Nathan A's description of *akiton*, in which Jewish villagers are asked to dig ditches and then line up at its edge to be shot, along with, later, all of their neighbors proceeds this way: (Nathan speaks, following here): 'They used to throw the earth on the top, and then the earth used to go up and down because they are living people: One–the son bury his mother; the mother was still alive.'" At this, the interviewer asks for clarification about the mother being buried alive, and Nathan is described as shrugging his shoulders without displaying any facial expression (p.2). This seemingly emotional indifference to being witness to what can only be described as a crime against humanity, is not unheard of among trauma survivors. This emotional insight, however, would be lost in a written testimony.

Conclusion and Gaps in Literature:

In conclusion, the literature that is available is an impressive collection of statistics, scientific studies, professional opinions, and some lived experiences. The head researcher of this capstone has found little to no writing that is centered around mental healthcare access for refugees and immigrants who have relocated around the greater Seattle area, or anything about their lived experiences. Seattle is one of the worst states in the nation for mental health care, and more research needs to be done to conduct proper analysis and provide adequate access to care.

There is an impressive collection of scientific data available, but the number of personal narratives from lived experiences are far harder to come by. There is also not as much information as I would have expected, regarding local, national, and international health budgets that go towards mental healthcare. The information that I have found so far is an excellent amalgamation of information, yet it remains incomplete. This is where my own research comes in. With more personal narratives, as well as local data, I plan to fill in some research gaps and perhaps influence local policy one day.

CHAPTER 3: METHODOLOGY

Methods:

This study employed a cross-sectional research design to collect survey data from n=30 participants from across the greater Seattle area. The researcher chose a cross-sectional design because it allowed for a broader reach of potential participants who were part of the targeted demographic for the research. It also allowed for a deeper understanding of differences and similarities across different communities.

Prior to doing any research, this study was submitted to the Institutional Review Board at the home institution, and it was determined that this study was classified as "exempt."

Design and Materials:

The design and materials used in this research, was a survey that was administered online and consisted of 17 questions. The survey was broken into sections. The first section included demographic questions on what country the participant was born in, what year they were born, and what religion(s) (if any) they practiced. The second section of the survey contained one matrix question. The question asked how the participant had been feeling over the past 6 months.

The rows/options available in this section "I have lost interest in doing things I used to love," "I have found it hard to go to school and/or work because I feel sad," "I am happy most of the time," "I am sad most of the time," "I am stressed most of the time," and "I am relaxed most of the time." There was a corresponding columns section, where the participant could choose "Strongly agree," "Agree," "Unsure," "Disagree," and "Strongly disagree." The third section of the survey contained 10 questions that asked about how participants experiences with doctors

and mental health providers had been, with a brief explanation on what a mental health provider is, the definition being presented in the survey as a doctor who helps a person with how they feel and behave. The first two questions "Have you ever gone to a mental health professional for any reason," and "Do you feel like it would help to talk to a doctor about speaking with a mental health professional" had the options of "yes" or "no" for an answer. The next two questions, "Do you comfortably speak with your family about your mental health without feeling judged" and "Can you speak with your friends comfortably about how you're feeling, without feeling judged" had three potential answer options, which were "yes," "No," and "It depends on the person." The final question in this section had a very narrow focus on diagnosable mental ailments. The question asked the participant "has a doctor ever diagnosed you with any of these," and then the answer options were listed as "attention deficit hyperactivity disorder (ADD/ADHD), "Anxiety," "bipolar disorder," "Post-Traumatic Stress Disorder," "Depression," "obsessive-compulsive disorder (OCD), and "Other: Please write here." This question allowed the participant to choose more than one answer if it was applicable that they had been formally diagnosed with more than one disorder. The following section of the survey contained 5 questions that asked the participant about their lifestyle habits, specifically over the past 6 months. The first question asked, "How many hours of sleep do you usually get at night", with the answer being multiple-choice, with the options of: "0 hours," "1-2 hours," "2-5 hours," "5-7 hours," "7-9" and "9+ hours." The next question asked the participant "do you use recreational marijuana?" (There was a clarification that this included edibles and joints). The answer options for this question were multiple choice, containing "yes," "No," and "Sometimes." There was a follow-up question to this that asked participants "If you do use recreational marijuana, how often do you use it?" The answer options for this were multiple choice as well, and contained "Less than 1 time per week," "Once per

week," "2 times per week," "3 times per week," "More than 3 times per week," and "Never." This section contained two more questions in the same vein as the marijuana questions, except these were about alcohol use. The first question about alcohol use asked participants "Do you drink alcohol," and provided multiple choice answers of "Yes," "No," and "Sometimes." There was a follow up question that asked participants "If you do drink alcohol, how often do you drink it?" The multiple-choice answers provided for this question were "Less than 1 time per week," "Once per week," "2 times per week," "3 times per week," "More than 3 times per week," and "Never." The final section of this survey asked participants to share their stories and lived experiences. These questions were open-ended, and the participant had the ability to free-write their answers. The first question in this section asked participants "I would like to know more about your immigration story. I value your lived experiences, and this will help us give you better access to mental health services." The second question in this section asked participants "What could social services do that would be very helpful to you?" This was the final question in the survey.

Measures:

A variety of variables were present in this study, and these can be further categorized into two categories: *nominal* variables and *ordinal* variables. The variables that fall under the *nominal* sector are: "COUNTRY," "REGION," "YRBORN," "AGE," "RELIGION," "SAMPH," "DWH," "CTTF," "CTTFR," "ANX," "DEPRESS," "ADHD," "PTSD," "BIPOLAR," "WEED," and "DRINK." The variables that fall under the *ordinal* sector are: "LOI," "HTA," "HAPPY," "SAD," "STRESS," "RELAX," "SLEEP," "SLEEP," "WTPW," and "DTPW."

Data Source:

The sample population who was part of this study come from a variety of religious and national backgrounds. All participants were at least 18 years old at the time of taking the survey. There was a total of 30 participants in the study. The demographic origins of participants include Israel, China, Fiji, Peru, Colombia, Vietnam, South Korea, South Africa, Australia, Ukraine, Russia, England, Brazil, Canada, Iran, and Iraq. Participants immigrated to the greater Seattle area, at some point in their lives. Some were also part of the University of Washington community and were in the area on a student visa, at the time of taking the survey. Participants took the survey for two primary reasons: The first being that the survey was about a subject they cared about on a personal level. The second is that there was a monetary incentive to be entered into a raffle once they had completed the survey to win a $25 gift card.

Procedures:

The study was distributed through a mass email that was sent to various organizations, as well as professors who are currently working at the University of Washington, who then sent the Email out to their classes. The organizations include two local synagogues, a large Mosque, and the Jewish Family Services of the greater Seattle area Student organizations on the University of Washington campus were also contacted. The author of this writing conducted the research activities as well.

Ethical Considerations:

Prior to conducting any research on live participants for the survey, the University of Washington Human Rights division board was contacted for approval. After getting an

exemption, due to the board concluding that risks and harms to the participants would be minimal, the survey was allowed to be conducted as planned. Regardless, prior to being able to take the survey, participants were given a consent form to read. Once they had read it, they were given the option to either continue the survey or opt-out. The only question that was mandatory was if they had read the form, agreed to take the survey, and met the requirements to participate. Voluntary participation and informed consent were among the most important factors in conducting the research present in this capstone. Maintaining confidentiality was highly prioritized as well, and in the case that confidentiality was broken, the results would be disregarded immediately. At the beginning of the survey, participants were informed that they could enter their email address to be entered in for a drawing for a gift card. This was optional, and participants were not obligated to enter their Email address.

Limitations:

This research presented several significant limitations. The first limitation that was encountered was timing constraints, as well as getting people to take the survey and answer the questions that were about a very sensitive and personal subject. It is difficult for many people to reveal their emotional trauma, and for many immigrants and refugees, even more so. Oftentimes, when refugees and immigrants share their most traumatic personal narratives, it is done in a very minimal way, rarely opening up to the point of giving much detail. There is also a cross-demographic and cross-cultural taboo against seeking mental health care or talking about mental health at all. People are often wary to share their mental health challenges with strangers, and this is especially true regarding the darker issues such as depression and suicidal ideation. This lack of information could skew the data and leave gaping holes in the research. Participants trusting this research enough to open up about their lives was a very difficult challenge, and

some participants changed their minds after initially agreeing to take the survey, which resulted in a smaller sample population than originally desired. The target demographic was already limited, and this shrunk the sample population even further.

Time constraints were another limitation that were present in this study. While some researchers can conduct a study over the span of several months, to even several years, this research only allowed data collected over the span of about 8 weeks. Finally, narratives, while collected and presented in this research, do not tell the full story, and do not tell the story of anyone except the narrator. As a Holocaust survivor who was cited in Bernard-Donals and Glezjner's writing, "I can only tell you my particular story, I can't tell you anything else" (p.10).

CHAPTER 4: RESULTS

Demographic Results

Demographic results of the survey provided 30 participants who came from 16 different countries of origin (see Appendix A, table A1). Iraq had the highest rate of participation, with 5 respondents (16.7%) being of Iraqi origin. The second highest rates of participation came from 4 Chinese participants who made up 13.3% of the sample population. Russians and Israelis tied for third highest rate of participation, with 3 participants each, making up 10% for each category. Brazil, South Korea, and Canada tied for fourth highest rates of participation, with 2 participants each, making up for 6.7% of participants, for each category. Australia, Fiji, South Africa, Ukraine, Peru, Vietnam, England, Iran, and Colombia had 1 participant from each country, representing 3.3% of the sample population for each category.

Religious demographic results were interesting, (see Appendix A, table A2), with Jews and Atheists providing the highest rates of respondents, with 8 and 7 respondents respectively, making for a combined percentage of 50% of all respondents. The third highest rate of participation came from Christians, with 5 respondents identifying as Christian, making up for 16.7% of all respondents. Muslims were fourth in prevalence, with 4 participants taking part in the survey, representing 13.3% of all respondents. Catholics and Buddhists represented 6.7% of the population each, with 2 participants being part of the survey from each category. Baha'i, Agnostic, and Unitarian participants provided for 3.3% of all respondents for each category, with only 1 member from each group participating in the survey.

Over half of all participants (see Appendix A, table A3), were between the ages of 18-30, with 18 people or 58.97% of all respondents being part of this age range. Participants who were ages 31-40 made up 16.6% of all participants. The next highest demographic age group was the

eldest group, those who were 60-80 years old, with 4 people, or 13.3% of all participants belonging to this demographic. Those who were ages 41-50 provided the smallest demographic, with only 3 participants, or 9.97% of all participants belonging to this age group.

Main Study Results

Main study results revealed a prevalence of social stigma surrounding mental health. When asked if one could speak to one's family comfortably about how one is feeling without feeling judged, (see Appendix B, table B1), the responses were that out of 30 respondents, 23.3% said "yes," 23.3% said "No," and the remaining 53.3% said "it depends." When asked about speaking to friends about how one is feeling without feeling judged, (see Appendix B, table B2) results were slightly more promising, with only 13.3% saying "No," while 43.3% said "it depends," and the remaining 43.3% saying "Yes."

Depression and anxiety disorders were the most commonly diagnosed disorders among the sample population, with 26.7% of respondents affirming that they had been formally diagnosed with an anxiety disorder, (see Appendix B, table B3) and 26.7% being diagnosed with depression (see Appendix B, table B4) (there is a chance of comorbidity with these results). Religion provided interesting results regarding feeling judged from friends and family regarding mental health status. Four out of five respondents who identified as Christian, stated that they could speak with their friends openly about their mental health, with one respondent saying they couldn't. Atheists had the lowest identifiable rates of comfort, with three respondents saying they could not speak with their friends, three saying it depended on who the friend was, and only one affirmed that they could speak with their friends comfortably about how they felt (see Appendix B, table B5).

Doctors were not automatically identified as being safe people to talk to for survey respondents. When asked if it would help to speak to a mental health professional, only 56.7% said it would, while the remaining 43.3% said it would not be helpful (see Appendix B, table B6). The numbers were the same for respondent answers when they were asked if they had ever seen a mental health professional before for any reason (see Appendix B, table B7)

Marijuana use was relatively low for respondents, with only 13.3% saying that they consumed it either occasionally or regularly, and the remaining 86.7% stating that they didn't consume any kind of marijuana (see Appendix B, table B8). Alcohol rates, however, were slightly higher. 60% of respondents stated that they did in fact consume alcohol, either occasionally or regularly, and 40% of respondents stated that they did not consume alcohol (see Appendix B, table B9).

Crosstab with Chi-Square results:

A chi square test revealed that the relationship between marijuana consumption and religious affiliation to be supported. X=41.37, df=14, p.001 (see Appendix C, table C1). Therefore, reject the null that states that there is a relationship between certain psychopathology and religious affiliation and statistical significance was proven. However, significance levels among every other crosstab with chi square that was run, were too low to prove any statistically significant data, so we failed to reject the null in these instances due to lack of evidence. In other words, the hypothesis that stated that immigrants and refugees experience higher levels of psychopathology could not be statistically proven with the survey data. Despite there being a lack of statistically significant data for the remaining tests, it is important to recognize that religion is sometimes a pre-indicator of war-torn regions, due to many wars having a religious basis.

The p-value was insignificant for most of the tests run, however, this survey was taken by immigrants who came from around the world, and the Chi-square results showed that psychopathology or related ailments such as high rates of alcohol consumption amongst the immigrant population, was indiscriminate of religious background, age, and country of origin. This is substantiated by the higher likelihood ratios that were collected that were closer to 1. A high likelihood ratio that is closer to 1 indicates that there is a strong likelihood of diagnosis for the specific ailment.

For BIPOLAR x RELIGION, the likelihood ratio was at .806 (see Appendix C, table C2). For RELIGION x ADHD, the likelihood ratio was at .818 (see Appendix C, table C3). For RELIGION x PTSD, the likelihood ratio was at .636 (see Appendix C, table C4). For RELIGION x ALCOHOL PER WEEK the likelihood ratio was at .909 (see Appendix C, table C5). For COUNTRY x ADHD, the likelihood ratio was at .761 (see Appendix C, table C6). For COUNTRY x BIPOLAR, the likelihood ratio was at .995 (see Appendix C, table C7). For AGE x STRESS, the likelihood ratio was at .777 (see Appendix C, table C8).

The variable SLEEP also produced high likelihood ratios. For AGE x SLEEP, the likelihood ratio was at .914 (see Appendix C, table C9). For RELIGION x SLEEP, the likelihood ratio was at .825 (see Appendix C, table C10).

Results of Qualitative Responses:

Numbers provide statistical support for scientific research, but they do not provide emotional, or verbal reasoning for the lived experiences behind the numbers. Narratives, however, fill this information gap. The following are carefully selected narratives, shared by participants who took a survey that was created by the head researcher, about their lived

experiences. These narratives will be categorized thematically, with a collection of quotations providing support for each theme. (*Note: There were over 20 responses for the prompted questions, and only a select amount are being shared in this writing due to brevity purposes).

Respondents provided a variety of commentary and feedback regarding their experiences as immigrants, asylum seekers, and refugees to the United States. The following 4 themes are categorized responses to the question "Tell us a bit about your immigration story." Following are the responses that were provided by participants. The following responses are categorized thematically.

Theme 1: Loneliness:

Social connections can provide a haven for many individuals, and this is no different for immigrants and refugees. These narratives also show that while one can be surrounded by people and be far from "alone," is it a very different experience compared to being "lonely." As one participant shared: *"I came to work and study English in the US in June 2018. My first year I lived in Marmora - New Jersey with a host family with a baby and 3 children. My second year I moved to Sammamish- WA to take care of a baby and boys twins 4 years old. Most of the time I was lonely with the kids, they were small and I would do my things (like eat meals, use the restroom, do house tasks when they were napping). I worked full time and I felt lonely many times. I think if I had older kids I would learn more and feel less lonely."* Experiencing a mental health psychopathological challenge is hard enough, but to do it alone is even worse. As mentioned throughout this writing, strong social circles are critical for positive mental health outcomes. Sometimes it can take months, or even years for one to find one's social circle and support system. As one participant shared: *"I moved to the U.S. as a kid. I have grown up apart*

from my culture, and it has often been difficult to find where I "fit in." Moreover, I have moved states a couple times and finally settled in Washington a few years ago. It would feel very lonely at times, but I have met some friends here that have been very supportive." Luckily, this participant has found a seemingly good support system and social network. However, the feeling of being an "outsider" because of one's culture, ethnicity, religion, race and/or background, may be a lifelong challenge. If one is part of a persecuted minority, concealing one's identity can be a matter of life or death.

Theme #2: Religious persecution:

As mentioned throughout this writing, religious persecution is a common cause for being forced to obtain refugee status. Individuals and their families are often left with no choice but to leave, as the only other options are either death or imprisonment. As one participant stated, after they had fled Iraq and moved to Jordan, they experienced significant discrimination for belonging to the minority Shiite Muslim sect. *"I went to Jordan where we basically didn't have any rights…for example, my brothers and I were forbidden to attend school… Also, whenever they catch that you are iraqi, they would ask if you are shia or suni right away and there's only one answer for this question which is " a sunni".* This narrative is harrowing, because there is an implication of violent retaliation if the answer to "what sect are you," is deemed socially unacceptable. Unfortunately, antagonism from society is far from the only concern that refugees often must experience, for family strife is another obstacle that many, like the following participant, have had to experience. With sometimes brutal outcomes: "*I moved from my country as a refugee due to my religion…After many years of family struggles, my parents got a divorce which caused some anger, resentment, and pain in me, and now 3 years later, I feel like I am*

going to seek a professional therapist to work some things out." This participant has not only experienced tragedy regarding their identity as belonging to a persecuted religious group, but they have experienced more acute personal hardships relating to their parents' divorce and their subsequent mental struggles. The statement about seeking out therapy is great on the surface because it illustrates deep personal insight and willingness to take the difficult step of seeking out therapy and admitting something is wrong. In the face of mental health stigma, this is excellent. However, access to these resources may prove to be difficult.

Theme #3: Access to healthcare:

Even if someone knows that they need help, sometimes they try everything in their power, yet to no avail. The problem is not a matter of self-doubt or stigma. The problem is lack of access to mental health resources. When questioned about what could be useful to participants for social services, greater access to mental health care was a common theme. The following participant provides a startling illustration of the struggle to obtain access to this much-needed resource: *"I don't have health insurance, neither a job. I would love to find a psychiatrist to help me understand why I don't feel joy anymore. And why my mood switches very quickly when I am home alone."* This participant not only is struggling with locating a therapist, but they are also experiencing related issues that are often clustered with lack of healthcare access: lack of employment, and lack of health insurance. This participant has provided deep personal insight into the necessity for an expansion of mental healthcare access. Sometimes, one will experience such significant mental health obstacles that gaining access to healthcare becomes an immediate life or death struggle.

<u>Theme #4: Mental Health psychopathology among immigrants and refugees:</u>

It is not just adults and adolescents that experience mental health crises, it's possible for young children and even infants to experience deep trauma that, if left unaddressed, can cause lifelong consequences. The following participant shares a narrative that is quite illustrative of this very serious matter: *"I was adopted at 9 months on the border of Russia close to North Korea. I came to the United States. I was diagnosed at a young age with ADHD and other learning disabilities. When I was in middle and high school I developed mental health problems. I also started getting concussions from sports and other activities which impacted my mental health immensely. I eventually got diagnosed with bipolar disorder. I take medication and it helps me out. I also have a therapist that I see and she is great."* This participant experienced a significant trauma as an infant with the experience of biological parental separation and faced additional mental health psychopathological challenges throughout their youth. This narrative provides critical evidence showing the urgent need for adequate mental health care throughout one's life if one is at risk for developing psychopathological conditions throughout one's life.

Discussion:

The original hypothesis stated that there were higher rates of psychopathology among immigrant and refugee populations, compared to native-born populations. There is strong evidence from secondary research that points to this hypothesis being true. However, primary research results did not provide strong evidence for this claim, as can be seen by consistently low P-values. However, it is important to note that this could be due to several factors, the biggest ones being a relatively small sample size. While secondary data provided various studies that had thousands of people as participants, the survey that was conducted by the head researcher of this capstone project, only had 30 participants. The lack of supportive primary research data could be due to

being too small of a sample size to make stronger evidentiary statements. Both primary and secondary data support the need for more resources to be put into mental health care and overall healthcare access.

CHAPTER 5: RECOMMENDATIONS

Policy recommendations:

The task of tackling mental health psychopathological conditions is an uphill battle. The data presented in this research, both secondary and primary alike, point to the need for further research and resources to be put into this issue. Statistical data supports the need for not only further quantitative research on the matter, but further qualitative research as well. Qualitative data also suggests a greater need for access to mental healthcare resources, as well as enhancing language access to individuals who specifically do not speak English fluently. If one goes to therapy but cannot understand what is being said, it is nothing short of a waste of time for both patient and therapist alike. Qualitative data suggests a demand for broad education on access to resources as well. Many participants stated that they did not know what social services were accessible or even available. Overall, mental health care access is equally as important as physical health care access, and the presented data provides support for more policies being drafted to further this cause.

References

1. Good, Byron J. “Mental Health Consequences of Displacement and Resettlement.” *Economic and Political Weekly*, vol. 31, no. 24, Economic and Political Weekly, 1996, pp. 1504–08, http://www.jstor.org/stable/4404273.

2. Savin, Daniel, et al. “Findings from Mental Health Screening of Newly Arrived Refugees in Colorado.” *Public Health Reports (1974-)*, vol. 120, no. 3, Sage Publications, Inc., 2005, pp. 224–29, http://www.jstor.org/stable/20056782.

3. Salami, Bukola, et al. “Migration and Social Determinants of Mental Health: Results from the Canadian Health Measures Survey.” *Canadian Journal of Public Health / Revue Canadienne de Santé Publique*, vol. 108, no. 4, Canadian Public Health Association, 2017, pp. e362–67, https://www.jstor.org/stable/90015942.

4. Bruce Bower. “Many Refugees Can’t Flee Mental Ailments.” *Science News*, vol. 159, no. 20, [Society for Science & the Public, Wiley], 2001, pp. 310–310, https://doi.org/10.2307/3981528.

5. Sim, Ryan. “Into the Mind of the Refugee: Unpacking Modern Refugee Mental Health.” *Harvard International Review*, vol. 37, no. 4, Harvard International Review, 2016, pp. 46–48, http://www.jstor.org/stable/26445618.

6. Hassan, Ahmad. “The Syrian Mental Health Crisis: Present Findings and Future Directions.” *Harvard Public Health Review*, vol. 21, Harvard T.H. Chan School of Public Health, 2019, pp. 1–5, https://www.jstor.org/stable/48515225

7. Corrigan, Patrick W., et al. “The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care.” *Psychological Science in the Public Interest*, vol. 15, no. 2, [Association for Psychological Science, Sage Publications, Inc.], 2014, pp. 37–70, http://www.jstor.org/stable/44151252.

8. Brune, M., Haasen, C., Yagdiran, O., & Bustos, E. (2003). Treatment of Drug Addiction in Traumatised Refugees: A Case Report. *European Addiction Research*, *9*(3), 144–146. https://www.jstor.org/stable/26790242

9. PUNAMÄKI, R.-L. (1988). POLITICAL VIOLENCE AND MENTAL HEALTH. *International Journal of Mental Health*, *17*(4), 3–15. http://www.jstor.org/stable/41344519

10. Ryan, D. A., Kelly, F. E., & Kelly, B. D. (2009). Mental Health Among Persons Awaiting an Asylum Outcome in Western Countries: A Literature Review. *International Journal of Mental Health*, *38*(3), 88–111. http://www.jstor.org/stable/41345295

11. The United States Government. (2021, May 3). *Statement by president Joe Biden on Refugee Admissions*. The White House. Retrieved June 12, 2022, from https://www.whitehouse.gov/briefing-room/statements-releases/2021/05/03/statement-by-president-joe-biden-on-refugee-admissions/

12. Awad, G. H., Castellanos, F., Dillard, J. B., & Payne, T. (2021). Coping With Trauma: Resilience Among Immigrants of Color in the United States. In P. Tummala-Narra (Ed.), *Trauma and Racial Minority Immigrants: Turmoil, Uncertainty, and Resistance* (pp. 229–244). American Psychological Association. http://www.jstor.org/stable/j.ctv1dwq1w7.18

13. Amy Shumam, & Bohmer, C. (2004). Representing Trauma: Political Asylum Narrative. *The Journal of American Folklore*, *117*(466), 394–414. http://www.jstor.org/stable/4137717

14. Bernard-Donals, M., & Glejzer, R. (2000). Between Witness and Testimony: Survivor Narratives and the Shoah. *College Literature*, *27*(2), 1–20. http://www.jstor.org/stable/25112512

15. Suicide and Suicidal Ideation Among Bhutanese Refugees — United States, 2009–2012. (2013). *Morbidity and Mortality Weekly Report*, *62*(26), 533–536. http://www.jstor.org/stable/24852304

16. Mayer, J.-F. (2007). INTRODUCTION: “IN GOD HAVE I PUT MY TRUST”: REFUGEES AND RELIGION. *Refugee Survey Quarterly*, *26*(2), 6–11. http://www.jstor.org/stable/45054198

17. Murray, K. (2022, June 20). *Addiction and refugees and immigrants*. Addiction Center. Retrieved July 11, 2022, from https://www.addictioncenter.com/addiction/refugees-immigrants/#:~:text=Substance%20abuse%20occurs%20in%20immigrant,compared%20to%20American%2Dborn%20individuals.

Appendix A

Demographic results of participants

Table A1

Country Born

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Israel	3	10.0	10.0	10.0
	Peru	1	3.3	3.3	13.3
	Brazil	2	6.7	6.7	20.0
	Russia	3	10.0	10.0	30.0
	Ukraine	1	3.3	3.3	33.3
	Fiji	1	3.3	3.3	36.7
	South Korea	2	6.7	6.7	43.3
	Canada	2	6.7	6.7	50.0
	South Africa	1	3.3	3.3	53.3

Iran	1	3.3	3.3	56.7
Iraq	5	16.7	16.7	73.3
Colombia	1	3.3	3.3	76.7
England	1	3.3	3.3	80.0
Australia	1	3.3	3.3	83.3
China	4	13.3	13.3	96.7
Vietnam	1	3.3	3.3	100.0
Total	30	100.0	100.0	

Note: This table provides information regarding the demographic variety of those who participated in the survey that was conducted by the head researcher of this capstone project.

Table A2

Religion

Frequency	Percent	Valid Percent	Cumulative Percent
Christianity 5	16.7	16.7	16.7

Catholicism 2	6.7	6.7	23.3
Judaism 8	26.7	26.7	50.0
Islam 4	13.3	13.3	63.3
Baha'i 1	3.3	3.3	66.7
Atheism 7	23.3	23.3	90.0
Agnostic 1	3.3	3.3	93.3
Buddhism 2	6.7	6.7	100.0
30	100.0	100.0	

Note: *This table provides information regarding the religious variety of those who participated in the survey that was conducted by the head researcher of this capstone project.*

Table A3

Age

	Frequency	Percent	Valid Percent	Cumulative Percent

Valid	20	5	16.7	16.7	16.7
	21	2	6.7	6.7	23.3
	23	1	3.3	3.3	26.7
	24	3	10.0	10.0	36.7
	25	2	6.7	6.7	43.3
	26	2	6.7	6.7	50.0
	27	2	6.7	6.7	56.7
	29	1	3.3	3.3	60.0
	34	1	3.3	3.3	63.3
	36	1	3.3	3.3	66.7
	39	1	3.3	3.3	70.0
	40	2	6.7	6.7	76.7
	45	1	3.3	3.3	80.0
	47	2	6.7	6.7	86.7
	61	1	3.3	3.3	90.0
	63	1	3.3	3.3	93.3
	69	1	3.3	3.3	96.7

	75	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

Note: This table provides information regarding the age range of those who participated in the survey that was conducted by the head researcher of this capstone project.

Appendix B

Main Study Results

Table B1

Can you talk to family without feeling judged?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	7	23.3	23.3	23.3
	yes	7	23.3	23.3	46.7
	it depends	16	53.3	53.3	100.0
	Total	30	100.0	100.0	

Note: This table provides information regarding whether or not participants can speak openly with their family members about their mental health and how they're feeling.

Table B2

Can you talk to friends without feeling judged?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	4	13.3	13.3	13.3
	Yes	13	43.3	43.3	56.7
	it depends	13	43.3	43.3	100.0
	Total	30	100.0	100.0	

Note: This table provides information regarding whether or not participants can speak openly with their friends about their mental health and how they're feeling.

Table B3

Diagnosed with anxiety

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	22	73.3	73.3	73.3
	Yes	8	26.7	26.7	100.0

	Total	30	100.0	100.0	

Note: This table provides information regarding how many participants in the study had a formal diagnosis with an anxiety disorder.

Table B4

Diagnosed with depression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	22	73.3	73.3	73.3
	Yes	8	26.7	26.7	100.0
	Total	30	100.0	100.0	

Note: This table provides information regarding how many participants in the study had a formal diagnosis with depression.

Table B5

		Can you talk to friends without feeling judged?			
		No	Yes	it depends	Total
Religion	Christianity	1	4	0	5
	Catholicism	0	0	2	2
	Judaism	0	4	4	8
	Islam	0	3	1	4
	Baha'i	0	0	1	1
	Atheism	3	1	3	7
	Agnostic	0	0	1	1
	Buddhism	0	1	1	2
Total		4	13	13	30

Note: This table is a cross-tabulation of religious affiliation, and comfort levels regarding particiaptns speaking to their friends about their mental health and how they're feeling.

Table B6

Would seeing a doctor help?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	10	43.3	33.3	33.3
	Yes	17	56.7	56.7	90.0
	Total	30	100.0	100.0	

Note: This table contains information regarding whether or not participants felt it would help to speak with a mental health professional.

Table B7

Have you ever seen a mental health professional for any reason?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	13	43.3	43.3	43.3

		Frequency	Percent	Valid Percent	Cumulative Percent
	Yes	17	56.7	56.7	100.0
	Total	30	100.0	100.0	

Note: This table provides information regarding whether participants had ever seen a mental health professional. It is important to note here that the reasons for speaking to one are not listed or mentioned, just that participants had, in fact, seen one, at least once in their lives.

Table B8

Do you consume weed in any form?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	26	86.7	86.7	86.7
	yes	3	10.0	10.0	96.7
	Sometimes	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

Note: This table provides information regarding whether participants consumed weed, either regularly, or occasionally.

Table B9

Do you consume alcohol?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	12	40.0	40.0	40.0
	Yes	6	20.0	20.0	60.0
	Sometimes	12	40.0	40.0	100.0
	Total	30	100.0	100.0	

Note: This table provides information regarding whether or not participants consumed alcohol, either occasionally, or regularly.

Appendix C

Chi-Square test results

Table C1

Note: For the following tables, the sections that are in **bold are the relevant data results.*

Religion * Do you consume weed in any form? Cross Tabulation

		Do you consume weed in any form?			
		No	yes	3	Total
Religion	Christianity	4	1	0	5
	Catholicism	2	0	0	2
	Judaism	7	1	0	8
	Islam	4	0	0	4
	Baha'i	0	0	1	1

	Atheism	7	0	0	7
	Agnostic	0	1	0	1
	Buddhism	2	0	0	2
Total		26	3	1	30

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**41.317[a]**	**14**	**.000**
Likelihood Ratio	**17.027**	**14**	**.255**
Linear-by-Linear Association	.059	1	.809
N of Valid Cases	30		

Note: This Table provides information regarding the relationship between marijuana consumption and religious affiliation.

Table C2

Religion * Diagnosed with Bipolar disorder Crosstabulation

		Diagnosed with Bipolar disorder		
		No	Yes	Total
Religion	Christianity	4	1	5
	Catholicism	2	0	2
	Judaism	8	0	8
	Islam	4	0	4
	Bahai'i	1	0	1
	Atheism	7	0	7
	Agnostic	1	0	1
	Buddhism	2	0	2
Total		29	1	30

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**5.172[a]**	**7**	**.639**
Likelihood Ratio	**3.765**	**7**	**.806**
Linear-by-Linear Association	1.810	1	.178
N of Valid Cases	30		

This table provides information pertaining to the relationship between religious affiliation and having a diagnosis of Bipolar Disorder.

Table C3

Religion * Diagnosed with ADHD Crosstabulation

		No	Yes	Total
Religion	Christianity	4	1	5
	Catholicism	2	0	2
	Judaism	7	1	8
	Islam	4	0	4
	Bahai'i	1	0	1
	Atheism	7	0	7
	Agnostic	1	0	1
	Buddhism	2	0	2
Total		28	2	30

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)

Pearson Chi-Square	**3.080[a]**	**7**	**.877**
Likelihood Ratio	**3.663**	**7**	**.818**
Linear-by-Linear Association	1.703	1	.192
N of Valid Cases	30		

Note: This table shows the relationship between religious affiliation and having a diagnosis of Attention-Deficit-Hyperactivity-Disorder

Table C4

Religion * Diagnosed with PTSD Cross Tabulation

		Diagnosed with PTSD		
		No	Yes	Total
Religion	Christianity	4	1	5
	Catholicism	2	0	2
	Judaism	8	0	8

	Islam	3	1	4
	Bahai'i	1	0	1
	Atheism	7	0	7
	Agnostic	1	0	1
	Buddhism	2	0	2
Total		28	2	30

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**5.089**[a]	**7**	**.649**
Likelihood Ratio	**5.193**	**7**	**.636**
Linear-by-Linear Association	.979	1	.323
N of Valid Cases	30		

Note: This table shows the relationship between religious affiliation and having a diagnosis of Post-Traumatic-Stress-Disorder.

Table C5

Religion * How many times per week do you consume alcohol Cross Tabulation

		How many times per week do you consume alcohol						Total
		Never	Less than 1X per week	Once per week	2X per week	3X per week	Missing	
Religion	Christianity	2	1	0	1	1	0	5
	Catholicism	1	1	0	0	0	0	2
	Judaism	3	4	1	0	0	0	8
	Islam	2	1	0	0	0	1	4
	Bahai'i	0	1	0	0	0	0	1
	Atheism	3	2	0	0	2	0	7
	Agnostic	0	1	0	0	0	0	1
	Buddhism	0	1	1	0	0	0	2

Total	11	12	2	1	3	1	30

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**28.490[a]**	**35**	**.774**
Likelihood Ratio	**24.436**	**35**	**.909**
Linear-by-Linear Association	.000	1	.998
N of Valid Cases	30		

Note: This table shows the relationship between religious affiliation and rate of weekly alcohol consumption.

Table C6

Country born * Diagnosed with ADHD Crosstabulation

		Diagnosed with ADHD		
		No	Yes	Total
Country born	Israel	3	0	3
	Peru	1	0	1
	Brazil	2	0	2
	Russia	1	2	3
	Ukraine	1	0	1
	Fiji	1	0	1
	South Korea	2	0	2
	Canada	2	0	2
	South Africa	1	0	1
	Iran	1	0	1
	Iraq	5	0	5
	Colombia	1	0	1
	England	1	0	1
	Australia	1	0	1

	China	4	0	4
	Vietnam	1	0	1
Total		28	2	30

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**19.286[a]**	**15**	**.201**
Likelihood Ratio	**10.877**	**15**	**.761**
Linear-by-Linear Association	1.803	1	.179
N of Valid Cases	30		

Note: This table shows the relationship between country of origin and having a diagnosis of Attention-Deficit-Hyperactivity-Disorder.

Table C7

Country born * Diagnosed with Bipolar disorder Crosstabulation

		Diagnosed with Bipolar disorder		
		No	Yes	Total
Country born	USA	4	0	4
	Israel	3	0	3
	Peru	1	0	1
	Brazil	2	0	2
	Russia	2	1	3
	Ukraine	1	0	1
	Fiji	1	0	1
	South Korea	2	0	2
	Canada	2	0	2
	South Africa	1	0	1
	Iran	1	0	1
	Iraq	5	0	5
	Colombia	1	0	1

	England	1	0	1
	Australia	1	0	1
	China	4	0	4
	Vietnam	1	0	1
Total		33	1	34

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**10.646**[a]	**16**	**.831**
Likelihood Ratio	**5.204**	**16**	**.995**
Linear-by-Linear Association	.434	1	.510
N of Valid Cases	34		

Note: This table shows the relationship between country of origin and having a diagnosis of Bipolar Disorder.

Table C8

Age * stress Crosstabulation

		STRESS				
		Disagree	Unsure	Agree	Strongly Agree	Total
Age	20	0	1	2	2	5
	21	0	1	1	0	2
	23	0	0	1	0	1
	24	1	0	2	0	3

	25	1	0	1	0	2
	26	0	1	1	0	2
	27	0	1	1	0	2
	29	1	0	0	0	1
	34	0	1	0	0	1
	36	0	0	1	0	1
	39	1	0	0	0	1
	40	0	1	1	0	2
	45	0	0	1	0	1
	47	0	0	2	0	2
	61	1	0	0	0	1
	63	0	1	0	0	1
	69	0	0	1	0	1
	75	1	0	0	0	1
Total		6	7	15	2	30

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**45.433[a]**	**51**	**.694**
Likelihood Ratio	**43.083**	**51**	**.777**
Linear-by-Linear Association	2.492	1	.114
N of Valid Cases	30		

Note: This table shows the relationship between the age of the participants and self-recorded stress levels.

Table C9

Age * How many hours of sleep do you get per night on average? Cross Tabulation

		How many hours of sleep do you get per night on average?				
		2-5 hours	5-7 hours	7-9 hours	9+ hours	Total
Age	20	0	3	2	0	5
	21	0	1	1	0	2

23	1	0	0	0	1
24	0	1	2	0	3
25	0	2	0	0	2
26	0	2	0	0	2
27	0	1	1	0	2
29	0	1	0	0	1
34	0	1	0	0	1
36	0	0	1	0	1
39	0	0	1	0	1
40	0	2	0	0	2
45	0	1	0	0	1
47	0	2	0	0	2
61	0	0	1	0	1
63	0	0	1	0	1
69	0	1	0	0	1
75	0	0	0	1	1
Total	1	18	10	1	30

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**76.622**[a]	**51**	**.012**
Likelihood Ratio	**37.872**	**51**	**.914**
Linear-by-Linear Association	2.897	1	.089
N of Valid Cases	30		

Note: This table shows the relationship between age of participants and self-recorded hours of sleep per night, on average.

Table C10

Religion * How many hours of sleep do you get per night on average? Cross Tabulation

How many hours of sleep do you get per night on average?				
2-5 hours	5-7 hours	7-9 hours	9+ hours	Total

Religion	Christianity	0	3	2	0	5
	Catholicism	0	0	2	0	2
	Judaism	0	5	2	1	8
	Islam	0	3	1	0	4
	Baha'i	0	0	1	0	1
	Atheism	1	4	2	0	7
	Agnostic	0	1	0	0	1
	Buddhism	0	2	0	0	2
Total		1	18	10	1	30

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**14.168[a]**	**21**	**.862**
Likelihood Ratio	**14.954**	**21**	**.825**
Linear-by-Linear Association	2.336	1	.126

N of Valid Cases	30		

Note: This table shows the relationship between religious affiliation of participants and hours of sleep participants received per night, on average.