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THE IMPACT OF STIGMA ON THE MENTAL HEALTH OF RESETTLED
AFRICAN AND ASIAN REFUGEES

A Dissertation Presented

by

Victoria M. Baptiste

to

The Faculty of the Graduate College

of

The University of Vermont

In Partial Fulfilment of the Requirements
For the Degree of Doctor of Philosophy
Specializing in Psychology

October, 2017

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October 2017

ABSTRACT

The global refugee crisis worsens day-by-day, with millions of refugees forced to seek safe haven abroad. Pre-migration trauma exposure contributes to disproportionately higher rates of psychopathology, especially among torture survivors and women. The extant literature has largely focused on the effects of pre-migration factors; however, increasingly, researchers recognize the critical impact of post-migration living difficulties (PMLD) in exacerbating refugee mental health. One example of a PMLD is stigma, defined as a socially devalued attribute (e.g., minority race, ethnicity, sex). A robust literature documents the deleterious effects of stigma on psychological functioning, but few studies of refugees have explored stigma, which is surprising because refugees often possess multiple stigmas. Given this gap in the literature, the present study examined the impact of stigma on psychological well-being in a sample of resettled refugees of mixed ethnic/racial and religious origins. Specifically, analyses tested (1) the independent effect of race among African and Asian refugees, (2) a linear model of multiple stigmas predicting mental health outcomes, and (3) between-group effects of race among Muslims and of religion among Asian refugees. Results showed that race significantly predicted posttraumatic stress symptoms among African and Asian refugees when controlling for sex and torture status, with Africans reporting higher levels of posttraumatic stress than Asians. Findings suggest that the effect of multiple stigmas on mental health outcomes is non-linear. Finally, results indicated that Muslim refugees experienced equivalent levels of anxious and general symptoms across racial groups; among Asians, significant between-group effects by religion were found for general symptoms. By understanding key factors impacting refugee mental health, more appropriate and efficacious interventions may be developed to treat this vulnerable population.

DEDICATION

For my first and most important teacher, my mother, Barbara Galle Baptiste,
whose lessons continue to soothe, sustain, and inspire me.

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Chapter 1: Introduction

Statement of the Problem

The world is facing a humanitarian crisis of staggering proportions. In 2015, persecution, violence, and human rights violations forced 1.8 million new refugees from their homes in search of safe haven, bringing the total number of refugees and asylum seekers worldwide to 21.3 million (United Nations High Commissioner for Refugees (UNHCR), 2017) and 3.2 million (UNHCR, 2016), respectively. The Syrian Arab Republic, Afghanistan, and Somalia produced over half of all refugees and asylum applications from unaccompanied or separated minors reached an all-time high (UNHCR, 2016). The number of forcibly displaced persons across the globe is the highest it has been since the aftermath of World War II, with 24 people newly displaced every minute.

Since 1975, the United States (U.S.) has granted permanent residency to more than three million refugees (DeSilver, 2015). Between the years 1975 and 2011, the U.S. led the world in number of refugees resettled annually, exceeding the number of individuals resettled during that time period in all other countries combined (Ott, 2011). In recent years, the U.S. capped annual refugee admissions at 70,000 (DeSilver, 2015), with priority given to the Burmese, Bhutanese, Iraqi, Iranian, and Congolese, in addition to religious minorities in the Former Soviet Union, Cubans, and minors from Central America (UNHCR, 2014). Under the Obama administration, the U.S. continued to rank first among all nations receiving refugees for resettlement, accepting 66,500 refugees in 2015 (UNHCR, 2016). In light of the mounting emergency in Syria, former President Obama planned to host 10,000 Syrian refugees (a five-fold increase over the prior year;

Harris, Sanger, & Herszenhorn, 2015) and to increase overall refugee admissions to 85,000 in 2015 and 100,000 the following year (DeSilver, 2015).

During his presidential campaign in 2016, Donald Trump released a statement “calling for a total and complete shutdown of Muslims entering the United States,” purportedly for reasons of national security (Huetteman, 2016). Since assuming the office of the President of the United States, Mr. Trump has twice attempted to make good on his campaign promises with two Executive Orders (No. 13,769, 2017; No. 13,780, 2017) identically titled, “Protecting the Nation from Foreign Terrorist Entry into the United States,” that intended to suspend immigration from seven Muslim-majority countries (Syria, Iran, Iraq, Libya, Sudan, Yemen, and Somalia) for 90 days, halt all refugee entries for 120 days, and ban Syrian refugees indefinitely pending review and revision of the refugee admission process (Zoppo, 2017). Although White House officials have backtracked from describing the orders as a “ban,” a judge presiding over *State of Hawai’i and Ismail Elshikh v. Donald J. Trump et al.* (2017) ordered a temporary restraining order blocking the revised order (Executive Order No. 13,780).

Citing “the dearth of evidence indicating a national security purpose” and “the president’s statements about a ‘Muslim ban,’ ” (*State of Hawai’i v. Donald J. Trump*, 2017, p. 39) U.S. District Court Judge Derrick K. Watson (of Hawaii) wrote:

It is undisputed...that these six countries have overwhelmingly Muslim populations...It would therefore be no paradigmatic leap to conclude that targeting these countries likewise targets Islam. Certainly, it would be inappropriate to conclude, as the Government does, that it does not (p. 31)... The record before this court is unique. It includes significant and unrebutted evidence of religious animus driving the promulgation of the Executive Order and its related predecessor (p. 33)... Plainly-worded statements, made in the months leading up to and contemporaneous with the signing of the Executive Order, and, in many cases, made by the Executive himself, betray the Executive Order’s

stated secular purpose. Any reasonable, objective observer would conclude, as does the Court...that the stated secular purpose of the Executive Order is, at the very least, 'secondary to a religious objective' of temporarily suspending the entry of Muslims. (p. 35-6)

The current U.S. political climate and emerging policies on immigration have propelled the national refugee program into the everyday consciousness of private citizens as never before. Some researchers (Bose, 2017) have observed that refugees are unwelcome in many U.S. communities as a result of “rampant Islamophobia, racism, and anti-immigration rhetoric.” Others refute these forces as motivators for public opinions and governmental policies regarding refugee resettlement. The persistence of both the administration, in continuing to advance legislation inhibiting travel and immigration, and of the court system, in impeding the proposed policies on constitutional grounds through a series of decisions, accentuates the present-day cultural and political divide in the U.S. As such, the time is ripe for systematic inquiry to explore the experiences of resettled refugees in the U.S.

The refugee experience is characterized by chronic traumatic stress (Fondacaro & Mazzulla, 2015b) that begins pre-migration (e.g., exposure to armed conflict, human rights violations, widespread violence), continues throughout the migratory process (i.e., displacement, resettlement), and endures post resettlement in a safe third country (e.g., acculturative stress, separation from loved ones, unemployment, poverty). The persecution that prompts refugees to flee is often accompanied by trauma exposure (for a review, see Steel, Chey, Silove, Marnane, Bryant, & van Ommeren, 2009), and in up to 35% of cases, torture (Basoglu, 1992). Overall, refugees display poorer mental health outcomes as compared to non-refugees, in part, owing to high rates of trauma exposure

(Fazel, Wheeler, & Danesh, 2005; Porter & Haslam, 2005; Silove & Ekblad, 2002). Not surprisingly, the focus of the extant literature has been on addressing the mental health consequences of pre-migration factors, such as exposure to trauma and torture.

Additionally, researchers have heavily emphasized posttraumatic stress disorder (PTSD) as a mental health outcome associated with the refugee experience (Fazel et al., 2005); however, some authors (Fondacaro & Mazzulla, 2015b) have called for the field to move beyond conceptualizing refugee's trauma responses within the Western diagnostic system, and PTSD, specifically. Increasingly, researchers are recognizing a more comprehensive constellation of trauma responses and, importantly, that the refugee's struggle does not end simply upon safe resettlement (Miller & Rasmussen, 2010).

Having achieved corporal security through resettlement, refugees then face a new set of challenges, including coping with tremendous loss and grief (Goodkind et al., 2013); changing social roles, social isolation, and lack of social support (Goodkind et al., 2013); unemployment (Goodkind et al., 2013; Teodorescu, Heir, Hauff, Wentzel-Larsen, & Lien, 2012) and underemployment (Hebbani, 2014); poverty (Goodkind et al., 2013), limited English language proficiency (Goodkind et al., 2013; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011); and intergenerational conflict (Khawaja & Milner, 2012); among other stressors. These post-migration living difficulties (PMLD) further exacerbate refugees' risk for poor psychological functioning (Gerristen et al., 2006; Goodkind et al., 2013; Miller, Omidian, Rasmussen, Yacubi, & Daudzai, 2008; Schweitzer et al., 2011; Schweitzer, Melville, Steel, & Lacherez, 2006). In particular, Goodkind and colleagues (2013) have suggested that the "powerful impact" (p. 2) of post-migration psychosocial stressors, including social inequalities, on refugee mental

health is “compounded by racism, discrimination, and marginalization of their cultural practices” (p. 2). Stigma—conceptualized here as a critical post-migration stressor—fuels prejudice, bias, discrimination, and oppression, and is far less studied in the refugee population despite the fact that quite often refugees constitute minorities in their resettlement communities by virtue of their race, ethnicity, religion, and immigration status.

With the widespread and long lasting effects of surviving trauma and/or torture (Lie, 2002; Silove et al., 2007; Teodorescu et al., 2012), the significant impact of post-migration living difficulties on functioning (Gerritsen et al., 2006; Goodkind et al., 2013; Miller et al., 2008; Schweitzer et al., 2011; Schweitzer et al., 2006), and the continuous influx of refugees into the U.S., the mental health of refugees represents a mounting public health concern. Moreover, in 2012, the World Health Organization (WHO) warned that “health cannot be achieved without addressing the social determinants of health” (p. 2). Recognizing the considerable contribution of stigma and social inequalities to health disparities, the WHO (2012, 2015) has called for a three-pronged global strategy that includes: (1) systematic measurement to better understand the problem and evaluate interventions, (2) improvement of daily living conditions; and (3) equitable distribution of resources, money, and power. As such, it is critically important to investigate the impact of post-migration living difficulties, such as stigma, on the psychological functioning of resettled refugees.

We will first provide important definitions serving to ground the reader’s understanding of the refugee experience. Next, the literature on refugee mental health, concentrating on the pre-migration experience, is reviewed. Then, a new framework for

conceptualizing the psychological sequelae of the refugee experience from pre-migration through the post-resettlement period is introduced. A review of the literature on post-migration living difficulties and their impact on psychological well-being follows, with particular emphasis on the social psychological construct of stigma, which forms the basis for the present research. Finally, the research aims, hypotheses, methodology, and results are discussed.

Definitions

In order to best understand the plight of refugees in the U.S., it is important to first define key terminology. The following section presents definitions for the terms “refugee,” “asylum-seeker,” and “resettlement,” providing a foundation upon which to review the present study.

Refugee. The United Nations defines a refugee as an individual whom “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country,” (UNHCR, 2015d). For example, the ethnic Lhotshampa (originally of Nepali ancestry) of Southern Bhutan; the Somali Bantu, an ethnic minority in Somalia; individuals caught in the crossfire of the Sunni-Shia religious schism; gay men, lesbians, and bisexual persons in countries where homosexuality is criminalized or civil rights protections are lacking (e.g., Saudi Arabia); and democracy and human rights activists in totalitarian and/or autocratic nations or those under military or single-party rule (e.g., the Democratic People’s Republic of Korea).

Refugees find themselves forcibly displaced, having fled armed conflict, gross

human rights violations, and/or generalized violence in their homelands (UNHCR, 2013, 2015c). The term “refugee” refers to one’s immigration status and indicates that one (1) has fled their country of origin, (2) sought protection in another country, and (3) subsequently, has been granted permanent residence status by a third state (UNHCR, 2011). In this way, refugees differ quite significantly from migrants, who have chosen to relocate in order to improve their prospects, often financially (UNHCR, 2015d).

However, it is important to note that the experiences of migrants are far from carefree and often closely resemble those of refugees in multiple ways excepting their routes of entry into the U.S.; for example, unaccompanied minors from Central and South America.

Asylum-seeker. Asylum-seekers are distinguished from refugees solely on the basis of the timing of their claims, with asylum-seekers posing their claims for asylum after crossing a port of entry into that country, whereas refugees are granted resettlement permission in advance (prior to having left the intermediary location; UNHCR, 2015a). In both cases, a grant of asylum or refugee status is a grant of permanent residency rights. To illustrate this semantic and legal distinction, consider the case of a Bhutanese refugee contrasted with a Togolese asylum-seeker. The former was expelled from Bhutan by the government due to ethnic-based policies and spent almost 20 years in a refugee camp in Nepal, from where he/she petitioned the United Nations High Commissioner for Refugees (UNHCR) for permanent resettlement in the U.S., and, upon being granted refugee status, departed for the U.S. The latter fled Togo fearing persecution for known anti-governmental political beliefs and activism, passing through several African countries before entering the U.S. via a tourist visa and later filing a claim for asylum (which would permit permanent residency). Given that the difference between refugees

and asylum-seekers lies in a technical and legal distinction and does not describe other more substantive differences, hereafter, the term refugee will be used to refer to both categories of resettled individuals.

Resettlement. UNHCR describes resettlement as one of three “durable solutions” to refugee displacement (UNHCR, 2015b). When other more preferable options, such as voluntary repatriation (i.e., returning to one’s country of origin) and integration into the community to which one has fled, are not possible, resettlement serves as an alternative. Thus, not all refugees are resettled: a subset is chosen for permanent relocation to a safe third country. In addition to providing permanent safe haven, resettlement (1) bars refoulement, or forcible return to a place where one’s life or freedom may be jeopardized for one of the aforementioned reasons (UNHCR, 2011); (2) affords refugees and their family members/dependents access to rights similar to those guaranteed to nationals; and (3) holds the opportunity to attain citizenship through naturalization (UNHCR, 2015b).

Chapter 2: Review of Literature

Refugee Mental Health

Compared to other populations, refugees display disproportionately high rates of psychological distress (Ellis, MacDonald, Lincoln, & Cabral, 2008; Fazel et al., 2005; Goodkind et al., 2013; Porter & Haslam, 2005; Silove & Ekblad, 2002). In particular, research shows elevated rates of PTSD, anxiety, and major depressive disorder (MDD) among resettled refugees (Gerritsen et al., 2006; Lindert, von Ehrenstein, Priebe, Mielck, & Brähler, 2009; Mollica, Sarajlić, Chernoff, Lavelle, Vuković, & Massagli, 2001; Roth, Ekblad, & Ågren, 2006), with symptoms persisting years after safe resettlement (Lie, 2002; Norredam, Garcia-Lopez, Keiding, & Krasnik, 2009; Silove et al., 2007; Teodorescu et al., 2012). Reported prevalence rates vary widely across studies and samples, with one study reporting that as many as 99% of their sample of refugees met diagnostic criteria for PTSD (de Jong, Mulhern, Ford, van der Kam, & Kleber, 2000) and up to 86% experienced clinically significant depressive symptoms (Fox & Tang, 2000). In their meta-analysis, Fazel and colleagues (2005) reported weighted prevalence rates of 9% for PTSD among adults (increasing to 11% among refugee children), 5% for MDD, and 4% for generalized anxiety disorder, with high comorbidity between PTSD and MDD. In samples including torture survivors, prevalence rates jump to almost 31% for both PTSD and MDD (for a review, see Steel et al., 2009).

Despite a high demonstrated need among resettled refugees (Porter & Haslam, 2005), mental health treatment needs remain largely unmet (de Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009), in part due to underutilization of services (Weine et al., 2000). Notwithstanding the variation in reported prevalence rates for mental health

problems, it is clear that research consistently supports a greater risk of psychopathology among refugees. Understanding key factors impacting refugee mental health is important to further our ability to intervene successfully with these populations. Research indicates that important factors include, but are not limited to, trauma and torture experienced by refugees and sex of the refugee.

Factors impacting refugee mental health.

Trauma. A large body of research has demonstrated a robust connection between exposure to trauma during the pre-migration period and refugee mental health outcomes (Goodkind et al., 2013; Silove & Ekblad, 2002; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Smith, Perrin, Yule, & Rabe-Hesketh, 2001; Steel, Silove, Phan, & Bauman, 2002; Teodorescu et al., 2012). Specifically, evidence suggests that pre-migration trauma predicts posttraumatic, anxious, and depressive symptoms in a number of refugee populations (Birman & Tran, 2008; Ichikawa, Nakahara, & Wakai, 2006; Schweitzer et al., 2011; Schweitzer et al., 2006). Indeed, refugees are most commonly assigned a diagnosis of PTSD (Fazel et al., 2005), which requires prior exposure to one or more traumatic events (American Psychiatric Association, 2013).

Moreover, features of the traumatic experience contribute to the level of resultant psychological distress. Research suggests a dose-response relationship by which increased trauma exposure is associated with greater symptom severity (Steel et al., 2009). This is exemplified by studies showing that both trauma number and severity impact symptomatology, with the experience of multiple (or cumulative) traumatic events related to increasing distress (Mollica, McInnes, Poole, & Tor, 1998). The type of trauma experienced can also affect psychological functioning (Silove & Ekblad, 2002). For

example, increased risk of adverse mental health has been demonstrated when trauma exposure includes torture, experiences in a concentration camp, or the use of rape as a political tool (Silove & Ekblad, 2002).

Torture. Some authors have argued that “torture represents a unique and particularly severe traumatic experience” (Baptiste, Fondacaro, Mazulla, Brassell, Pichler, & Harder, 2015, p. 6). The United Nations (UN) defines torture as an act that is intentionally inflicted in order to cause severe physical or mental pain or suffering for reasons of obtaining information or a confession; intimidation or coercion; punishment; or state-sanctioned discrimination (International Rehabilitation Council for Torture Victims (IRCT), 2013). Although condemned as inhumane by the UN’s Convention Against Torture nearly three decades ago, torture remains a widely used practice that has been documented in 112 countries around the world (Amnesty International, 2013) and is considered “endemic” (Steel et al., 2009, p. 547) in countries affected by widespread armed conflict. It has been reported that as many as 35% of refugees report a history of torture (Basoglu, 1992).

Given the strong association of trauma with psychopathology and the observed dose-response relationship between trauma and refugee mental health, it is not surprising that torture is related to increased occurrence of mental health problems in the refugee population. Indeed, physical and psychological torture were independently associated with PTSD symptoms in a sample of former political prisoners, with the combined effect particularly pronounced (Punamäki, Qouta, & Sarraj, 2010). Torture survivors also display greater depressive symptomatology than refugees without a history of torture (Rončević-Grzeta, Frančišković, Moro, & Kaštelan, 2001; Shrestha et al., 1998).

Likewise, in their meta-analysis, Steel and colleagues (2009) found that torture exposure accounted for the highly inflated PTSD and depression prevalence rates reported across studies of refugees. After adjusting for methodological factors, they showed that exposure to torture explained 23.6% of the inter-survey variance in reported PTSD rates and 11.4% of the variability between surveys in reported rates of depression. In the case of PTSD, torture was identified as the most influential variable among the substantive factors contributing to posttraumatic stress symptoms.

Sex. Across several studies, refugee women have displayed poorer mental health than males, perhaps due to their increased vulnerability to certain types of trauma, such as sexual assault (actual and threatened) and psychological warfare (e.g., harassment, assault and/or torture of family members, violent death of spouse or children; Ekblad, Prochazka, & Roth, 2002; Hooberman, Rosenfeld, Lhewa, Rasmussen, & Keller, 2007). Such experiences may exacerbate the psychological sequelae of trauma exposure among women (Ekblad et al., 2002). Indeed, research demonstrates a relation between rape and the severity of posttraumatic and anxious symptoms in refugee women (Hooberman et al., 2007). Additionally, in a meta-analysis investigating potential moderating effects on refugee mental health, Porter and Haslam (2005) found an association between female sex and greater psychopathology. Since then, studies have corroborated earlier findings, reporting increased rates of mood disorders among female Yugoslavian refugees (Bogic et al., 2012) and greater posttraumatic, anxious, and depressive symptomatology among female refugees from Afghanistan, Iran, and Somalia (Gerritsen et al., 2006). Compared to male torture survivors, female torture survivors of diverse ethnic backgrounds endorse more symptoms of PTSD (Ayazi, Lien, Eide, Swartz, & Hauff, 2014; Schubert &

Punamäki, 2011), depression (Schubert & Punamäki, 2011), and general psychological distress (Ayazi et al., 2014).

However, some studies have suggested that psychopathology does not differ across the sexes. When adjusting for methodological factors, Steel and colleagues (2009) reported that sex did not impact PTSD or depression prevalence. Likewise, more recently, authors have reported no sex differences with respect to PTSD (Perera et al., 2013) or anxiety disorders (excluding PTSD; Ayazi et al., 2014). Interestingly, in a sample of Somali and Oromo refugees, sex interacted with ethnicity such that Oromo men endorsed more posttraumatic symptoms than Oromo women, whereas there were no differences in symptoms between Somali males and females (Perera et al., 2013). Of note, the effect may have been confounded by Oromo men's increased exposure to torture (Jaranson et al., 2004; Perera et al., 2013).

Other factors impacting refugee mental health. Taken together, evidence strongly suggests that torture survivors (Rončević-Grzeta et al., 2001; Shrestha et al., 1998; Steel et al., 2009) and women (Bogic et al., 2012; Gerritsen et al., 2006; Porter & Haslam, 2005) report greater psychopathology than persons without a history of torture and men, respectively. Interestingly, recent research from our laboratory (Baptiste et al., 2015) challenges these results. Our findings indicate that refugee mental health may not differ on the basis of either torture history or sex. Indeed, across the sample, mean depression and anxiety scores far surpassed clinical cut-offs, suggesting that regardless of sex or torture status, on average, refugees report high rates of psychological distress. One exception is PTSD, as unexpectedly, the mean PTSD score for the sample fell below the clinical threshold for PTSD, despite a high level of reported trauma, and in 78% of cases,

torture. As such, our results suggest that other characteristics of the refugee experience (e.g., post-migration stressors) may override the impact of torture history and sex in predicting psychopathology in a traumatized population.

Additionally, a number of other factors impacting refugee mental health have been reported in the literature. Porter & Haslam's (2005) meta-analysis identified a relation between psychological distress and older age, greater educational attainment, higher socioeconomic status, and residing in a rural environment (prior to resettlement). Increasingly, researchers are calling attention to the effects of post-migration stressors on refugee mental health outcomes.

“Moving beyond PTSD” (Fondacaro & Mazzulla, 2015a)

Despite the fact that PTSD is one of the most common conditions diagnosed and studied in refugee populations (Fazel et al., 2005), it is becoming more and more evident that PTSD does not fully describe the psychological sequelae associated with the refugee experience. With refugee populations, in particular, it may be prudent to consider an expanded set of experiences beyond those delineated by the *Diagnostic and statistical manual of mental disorders* (American Psychiatric Association, 2013; Fondacaro & Mazzulla, 2015b). For example, PTSD conceptualizes trauma-related socioemotional responses as past-oriented, and therefore focused on events that have concluded; however, the traumatic experiences of refugees more commonly represent ongoing events and reactions (especially for those from regions where the conflict has yet to be resolved).

Moreover, following safe resettlement, refugees encounter a variety of novel stressors with the potential to impact psychosocial functioning. For example, a Somali

refugee woman who has personally experienced the trauma of rape in her country of origin may continue to suffer emotional distress post-resettlement when she learns of the deaths of loved ones back home, given that, at present date, civil war is ongoing in Somalia. The current diagnostic criteria for PTSD do not account for reactions to any such present-day or ongoing events/stressors. And, although alternative conceptualizations have been developed to classify responses to traumatic events (e.g., Complex PTSD, Complex Developmental Trauma, Disorders of Extreme Stress Not Otherwise Specified), these categorizations also appear to lack some applicability to refugees and torture survivors in that they, too, ignore cultural considerations and context, are past-oriented, and do not account for the full spectrum of clinical presentations exhibited by refugees and/or torture survivors (Fondacaro & Mazzulla, 2015b). Likewise, the limited lens through which PTSD and other conceptualizations view trauma-related responses does not account for outcomes associated with strength and resilience variables. Consequently, it may be necessary to develop new and expanded formulations to explain the psychological corollaries of exposure to trauma and torture among refugees.

Toward this end, Fondacaro and Mazzulla (2015b) have introduced a conceptualization that “moves beyond” the Western diagnostic classification for use with cross-cultural populations who have experienced severe and widespread violence and trauma. They describe the refugee experience as characterized by chronic traumatic stress (CTS). According to Fondacaro and Mazzulla (personal communication, October 2015), “CTS is not a disorder but rather the contextual experience of persistent traumatic event(s), both past and continued that occur at any point across the lifespan, with

sequelae that are perceived by the individual as impairing, regardless of symptom constellation or thresholds.” In this manner, the CTS framework embraces a more inclusive, non-pathological perspective that recognizes the unique and understandable psychological reactions of refugees to persistent traumatic experiences across time (Baptiste et al., 2015).

Furthermore, the CTS paradigm is unique in placing refugees’ psychological responses to stressors within a much larger cultural context and recognizing not only past and ongoing traumatic experiences, but also other stressful current life events (Fondacaro & Mazzulla, 2015b). This is especially important as the remediation of some such post-migration living difficulties (e.g., homelessness, acute medical care needs) may take precedence over psychological interventions for trauma-related symptomatology (Fondacaro & Mazzulla, 2015b), whereas successful culturally-competent treatment must address other chronic problems (e.g., structural social inequalities) concurrently.

Testing the chronic traumatic stress (CTS) framework. With its emphasis on the importance of measuring and addressing ongoing stressors, the chronic traumatic stress (CTS) framework (Fondacaro & Mazzulla, 2015b) serves as a theoretical basis for testing the impact of post-migration living difficulties on refugee mental health. One example of a post-migration living difficulty that has been largely overlooked in the research is stigma (see definition below). Stigma permeates the daily life of refugees resettled abroad as refugees often represent one or more stigmatized groups due to minority race, ethnicity, and/or religion. The present research sought to fill this gap in the literature by examining the impact of stigma on the psychological functioning of resettled refugees.

Post-migration Living Difficulties (PMLD)

Post-migration living difficulties (PMLD) encompass stressors and problems encountered by refugees after they have achieved safe relocation. Separate from issues related to pre-migration trauma and the stress of transit, PMLD uniquely describe the refugee's experiences in the place in which they have resettled. These problems include, but are not limited to, the process of acculturation (Birman & Tran, 2008); intergenerational conflict (Khawaja & Milner, 2012); underemployment (Hebbani, 2014) and unemployment; poverty; separation from family members, loss, and grief; weak social support; loss of important social roles and/or status; impoverished sense of environmental mastery; limited English language skills; and discrimination and marginalization (Goodkind et al., 2013). Lindencrona, Ekblad, & Hauff (2008) have proposed that PMLD can be organized along four dimensions: (1) social and economic strain, (2) alienation, (3) discrimination and status loss, and (4) violence and threats, which together account for a majority of the variance in resettlement-related stress. Stigma represents two of the aforementioned dimensions, as stigma is the underpinning of discrimination and a trigger for social alienation. Research suggests that among refugees resettled in the United States, the most salient daily stressors cited relate to language barriers (Goodkind et al., 2013; Schweitzer et al., 2011), inadequate social support (Goodkind et al., 2013; Teodorescu et al., 2012), and worries about relatives who reside in other countries (Schweitzer et al., 2011).

Post-migration living difficulties (PMLD) and psychological well-being.

Refugees routinely report multiple severe pre-migration traumas that impact their psychological functioning (Schweitzer et al., 2011), but increasingly research is

demonstrating the effects of post-migration stressors on refugee mental health (Goodkind et al., 2013; Miller & Rasmussen, 2010). As is the case with other minority groups in the United States, refugees are subject to social inequalities (e.g., inequities in employment, housing, education, general resources and access) that contribute to health disparities (Goodkind et al., 2013). A number of studies across various populations of individuals exposed to war have demonstrated a relation between daily stressors and increased distress levels (Fernando, Miller, & Berger, 2010; Miller et al., 2008). Specifically, higher rates of PTSD, anxiety, depression (Gerritsen et al., 2006; Schweitzer et al., 2011; Schweitzer et al., 2006), and somatization (Schweitzer et al., 2011) have been shown to be related to increased stress levels. Studies have also found that factors such as unemployment and poor social support and social integration are associated with increased symptom severity and high rates of comorbidity (e.g., of PTSD and depression, of PTSD and two or more additional diagnoses; Teodorescu et al., 2012). Conversely, studies have related good social support (Birman & Tran, 2008; Carlsson, Mortensen, & Kastrup, 2005; Schweitzer et al., 2006) and English language proficiency (Beiser & Hou, 2001) to positive mental health outcomes.

Notably, Schweitzer and colleagues (Schweitzer et al., 2011) reported that PMLD made a unique contribution to explaining anxious, depressive, and somatic symptoms independent of pre-migration trauma exposure; and in the case of PTSD, roughly equaled the influence of level of trauma exposure. These findings substantiate an earlier study of Iraqi refugees that demonstrated a stronger relation of poor social support to depressive symptoms than between trauma and depression (Gorst-Unsworth & Goldenberg, 1998) and a number of qualitative studies wherein refugees reported that, compared to current

stressors, trauma had a less salient effect on their well-being (Carlsson, Mortensen, & Kastrup, 2005; Tempany, 2009). More recently, it has been suggested that in the case of depression, PMLD may interact with level of trauma exposure such that symptoms are exacerbated in the face of increasing PMLD for individuals exposed to low levels of trauma (Bentley, Thoburn, Stewart, & Boynton, 2012). In sum, studies consistently provide support for the finding that refugee mental health is significantly impacted by post-migration living difficulties.

Stigma as a Post-Migration Living Difficulty

Defining stigma. Although stigma has been conceptualized in many different ways over time, all definitions have at core Erving Goffman's (1963) description of stigma as "an attribute that is deeply discrediting," which demotes the individual "from a whole and usual person to a tainted, discounted one" (p. 3). Stigma marks individuals as different and, thus, devalued by others (Major & O'Brien, 2005). Discredited or stigmatized attributes include those relating to race and ethnicity, sex/gender, social class, physical appearance (e.g., disability, deformity), and sexual orientation, among others (Cole, 2009; Earnshaw, Bogart, Dovidio, & Williams, 2013; Major & O'Brien, 2005). Stigmatized attributes give rise to stigmatization via an attributional process by which stigma first conjures negative dispositional associations (i.e., prejudice and stereotypes) and, then, drives others' interpretations of and responses (e.g., discrimination) to the stigmatized individual (Baptiste, 2014; Crocker, Major, & Steele, 1998; Jones, Farina, Hastorf, Markus, Miller, & Scott, 1984; Major & O'Brien, 2005). Stigmatization, then, is a socially-constructed, context-dependent process through which an individual or group is globally devalued based upon possession of a discredited attribute, ultimately leading

individuals to be ignored or excluded from social interactions (Baptiste, 2014; Crocker et al., 1998; Elliott, Ziegler, Altman, & Scott, 1982; Goffman, 1963; Jones et al., 1984; Kurzban & Leary, 1989; Link & Phelan, 2001; Major & O'Brien, 2005).

Some theorists have conjectured that the degree to which an individual experiences stigmatization is determined by variables that mediate stigma severity (Kurzban & Leary, 1989). Jones and colleagues (1984) introduced six dimensions purported to affect stigma severity: (a) visibility-concealability, (b) origin, (c) course, (d) disruptiveness, (e) aesthetic qualities, and (f) peril.

Visibility-concealability. When stigma is highly visible, as when stigma is physically apparent (e.g., burn scars, race as signified by skin color), stigma is increased and consequently, social interactions are negatively impacted. However, the more inconspicuous a stigmatizing attribute is, the lesser the negative consequences (Frale, 2014), leading some to purposefully attempt to conceal a stigmatizing attribute so that it is unobservable to others, as in the case of gay, lesbian, and bisexual people who do not disclose their sexual orientation; and individuals of Black or African racial ancestry who do not display the characteristic phenotype (e.g., brown or black skin, tightly curled dark hair) and thus “pass” for White (Goffman, 1963; Jones et al., 1984).

Origin and course. Perceptions of stigma origin and course are largely tied to the notion of controllability (Jones et al., 1984). Origin refers to the manner by which the stigma came to be, whereas course describes the degree to which the stigmatizing attribute can be changed (Jones et al., 1984; Kurzban & Leary, 1989). When one is perceived to have control over the stigmatizing mark, negative attitudes and behaviors toward them increase. For example, eating disorders and drug use/abuse are often thought

to be matters of choice and therefore highly stigmatized. Similarly, a case can be made for the intensification of HIV-related stigma based on its association with other highly stigmatized attributes (particularly behaviors), such as intravenous (IV) drug use and homosexual sex (Chang et al., 2014; Duffy, 2005; Herek & Glunt, 1988; Mawar, Sahay, Pandit, & Mahajan, 2005; Mill, 2001; Mill, Edwards, Jackson, Austin, MacLean, & Reintjes, 2009; Mill, Edwards, Jackson, MacLean, & Chaw-Kant, 2010; Novick, 1997; Reidpath & Chan, 2005). Importantly, although beliefs about control can be important with certain types of stigma, controllability may not always be relevant (Kurzban & Leary, 1989). This is best exemplified by racial/ethnic minorities and low-ranked members in caste systems who experience pervasive stigmatization despite an obvious inability to control their group membership (which was assigned to them at birth). Similarly, individuals who contracted HIV/AIDS through a blood transfusion (Sheehan, Lennon, & McDevitt, 2001) are stigmatized, though to a lesser extent than those believed to have been infected through homosexual sex or IV drug use (Pullium, 1993).

Disruptiveness. In some cases, stigma leads to social rejection because some characteristics, like mental illness, disrupt normal social interactions (Baron-Cohen & Bolton, 1993; Jones et al., 1984). Conversely, stigmatization itself can be disruptive, as when racial stigma intrudes on interracial interactions (Ickes, 1984).

Aesthetics & Peril. Finally, people with conditions that involve features regarded as more aesthetically unpleasant or that suggest greater danger experience stigmatization to a greater extent (Jones et al., 1984). A classic historical example is leprosy, or Hansen's disease, which is a chronic bacterial infection sometimes characterized by skin lesions, inflammation, and other physical distinctions, that is passed person-to-person. To

date, in certain parts of the world, persons infected with Hansen's disease are quarantined in leper colonies and shunned from participation in the greater society.

Differentiating stigma from other related terminology. Of note, the terms, "prejudice," "stereotype," and "discrimination" are often incorrectly used as synonyms for stigma (Major & O'Brien, 2005). Although highly related, stigma represents a more comprehensive construct (Major & O'Brien, 2005), whereas prejudice, stereotypes, and discrimination are manifestations of stigma (Dovidio et al., 2008). To clarify: prejudice refers to preconceived notions, often negative and based on perceptions of another's group membership, that are made without awareness of pertinent facts; stereotypes reflect beliefs and expectations about individuals and/or groups that are applied in a sweeping manner; whereas discrimination describes differential treatment and/or consideration on the basis of one's group membership (Earnshaw et al., 2013; Sue & Sue, 2013).

Stigma and refugees. By virtue of their immigration status alone, refugees and asylum-seekers constitute a stigmatized group. Additionally, many refugees will possess other stigmatizing attributes, especially those relating to racial/ethnic and/or religious identity (and for approximately 50% of resettled refugees, female sex). In fact, given that many national conflicts are based on racial/ethnic and/or religious differences, it is quite plausible that a refugee will have experienced stigmatization on account of their group membership both in their country of origin and also in their resettlement community, where the demographic composition may be starkly different.

Stigma and psychological well-being. The extant research on stigma indicates that possessing stigmatizing attributes confers increased risk for poor psychosocial functioning (Link & Phelan, 2001). Meyer's (1995, 2003) minority stress model seeks to

explain the relation between stigma and psychological well-being, positing that stigmatized individuals experience chronic stress that is directly related to their stigmatization, thus inflating their risk for mental health problems (Logie, Newman, Chakrapani, & Shunmugam, 2012). Over time, the discrepancy between culturally valued traits (e.g., Whiteness, Christianity) and the devalued attributes possessed by minorities results in persistent minority stress characterized by prejudice, hostility, exclusion, discrimination, and victimization (Every & Perry, 2014; Meyer, Schwartz, & Frost, 2008). Regarding the social exclusion that accompanies stigmatization, Richman and Leary (2009) assert that "...acceptance and belonging is necessary for psychological and physical well-being...people who do not have their belonging needs satisfied...will be in a state of deprivation that causes immediate effects on thought, emotion, and behavior, and if prolonged, a variety of long-term negative effects on health and adjustment" (p. 366). As such, stigma (and related constructs such as discrimination) serves as an example of an important post-migration stressor with the potential to impact refugee mental health.

Race, color, stigma, and psychological well-being. One example of a highly stigmatized attribute is race. Race is a social construct built upon the assumption that people can be separated into meaningful groups based on phenotype (Bonilla-Silva, 2009). The U.S. Census Bureau (2013) recognizes five racial categories: White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander.

Some authors have described race-related stigma as causing "debilitating damage...[on] the human psyche" (Howarth, 2006, p. 449). In their study of the correlates of African Americans' mental health, Klonoff, Landrine, and Ullman (1999)

reported that when racial discrimination increased, symptoms of anxiety, depression, interpersonal sensitivity, and somatization also increased. Perceived race-related stigma has also been associated with increased rates of substance use among Black adolescents as well as their parents (Gibbons, Etcheverry, Stock, Gerrard, Weng, Kiviniemi, & O'Hara, 2010).

An important related issue that has sometimes been obscured by the traditional scholarly discourse on race is colorism (Hunter, 2007), despite the fact that its roots trace back to colonial times, the social dynamics of plantation life, and early Asian class systems. The highly complex system of racism operates along at least two levels: (1) race, or the categorization into a racial category (as described above); and (2) color, or more precisely the perceived appearance of one's skin tone as light or dark (Hunter, 2007). Colorism describes the process by which light-skinned persons of color receive privileges and advantages over their darker-skinned counterparts through proximity to an idealized White archetype (Burke & Embrich, 2008; Hunter, 2005, 2007). Colorism has been described as a surreptitious force behind internal differentiation and inequality among people of color (Burton, Bonilla-Silva, Ray, Buckelew, & Hordge Freeman, 2010) that is equivalent to the impact of race (Hill, 2000; Wade, 2005).

A budding literature has documented disparities among people of color that privilege the lighter skinned and disadvantage the darker skinned with respect to legal sentencing (Maxwell, Brevard, Abrams, & Belgrave, 2015), income, employment rates, occupational prestige, poverty, access to housing in unsegregated neighborhoods, educational attainment, and access to high status marriage partners (i.e., those who have achieved a high level of education, income, and occupational prestige; for a review, see

Hunter, 2007). These findings have held even when controlling for other variables (e.g., family background, occupation, and education level). Moreover, Tetey-Fio (2006) explains that presently, Black immigrants are subject to the same color line and color-based system of privileges and disadvantages established in early American history, whereas Russian and Ukrainian refugees have been afforded a sense of invisibility through their whiteness that permits a more seamless integration and acculturation process (Hardwick, 2006).

Colorism has been described as “ubiquitous yet understudied” (Marira & Mitra, 2013, p. 103). Demand for skin-lightening (or bleaching) products among men and women globally is on the rise, especially in Africa, Asia, and Latin America, as people of color seek the social and economic advantages of light skin (Perry, 2006). To African and Asian refugees, colorism is a familiar construct that may be amplified upon introduction to U.S. racial and skin color dynamics post-resettlement.

Sex, stigma, and psychological well-being. Despite great progress over time, sex-based stigmatization is ever-present. The American wage gap remains, women are disproportionately at risk for physical assault and rape, and overall, females consistently display poorer psychological health as compared to males (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; McLean, Asnaani, Litz, & Hofmann, 2011; Ussher, 2010). As with race-related stigma, exposure to sexist events is associated with adverse psychological outcomes (Thompson Sanders, Noel, & Campbell, 2004). Specifically, several studies have demonstrated that sex-based discrimination predicts anxious, depressive, obsessive-compulsive, and somatic symptoms among women of diverse racial backgrounds (Klonoff, Landrine, & Campbell, 2000; Landrine, Klonoff, Gibbs,

Manning, & Lund, 1995; Perrin et al., 2014). Such findings raise the question of whether stigma may help to explain the higher rates of psychopathology consistently observed among women.

Religion, stigma, and psychological well-being. Although believed by some to be antiquated, religious stigmatization remains a global phenomenon. Between 1990 and 2002, religious discrimination rose 11.4% worldwide and 7.9% in Western democracies, increasing in each region of the world (except Latin America) and within all religious traditions (Fox, 2007). Additionally, the first 10 years of the new millennium saw workplace religious-based discrimination claims rise dramatically in the U.S.: a 96% increase, which far outnumbered claims made on the basis of other protected statuses (i.e., race: 24% increase, sex: 15% increase, national origin 45% increase; Fox & Akbaba, 2015). For example, in a post-9/11 era, Islamophobia, in particular, has been rampant (Fox & Akbaba, 2015), with women presumed to shoulder a heavier burden of anti-Muslim stigma given the very visible religious identity marker of the *hijab* (Jasperse, Ward, & Jose, 2012). As recently as 2009, Stuart and Ward found that as few as 15% of New Zealanders believed wearing a headscarf wherever one wants is acceptable and 47% of survey respondents opposed the wearing of *burqas* in the country.

A small set of studies have explored the relation between religious stigma and psychological well-being among Muslims, with interesting findings. For example, Jasperse and colleagues (2012) demonstrated that wearing a *hijab* served a protective function for Muslim women with respect to increased life satisfaction and reduced psychological distress. Additionally, they found that perceived religious discrimination interacted with Muslim identity such that individuals with stronger Muslim identity

displayed greater susceptibility to the negative psychological effects of religious discrimination. Furthermore, a high level of engagement in Islamic religious practices buffered the association between perceived discrimination and psychological outcomes, whereas increased symptomatology was exhibited by individuals who engaged in Islamic practices at a low to moderate level. Every and Perry (2014) reported findings in support of the minority stress model among Muslim migrants in Australia, who showed a relation between perceived interpersonal religious discrimination (e.g., insults, physical distance) and decreased self-esteem. On the other hand, perceived institutional discrimination was related to an increase in self-esteem, perhaps by activating in-group identification.

Interestingly, some authors (Colic-Peisker, 2009) have suggested that Muslims with light skin who do not display visible markers of their religion (e.g., attire) may experience less prejudice and discrimination than dark-skinned Muslims who are visibly different. Moreover, research has shown that the experience of racial/ethnic prejudice and discrimination may occur simultaneous to or separate from religious prejudice/discrimination (Salleh Haddin & Pedersen, 2012; Weller, Feldman, Purdam, & Andrews, 2001). Collectively, these findings underscore the complexity of the relation of stigma to psychological well-being and the need for further investigation.

Amidst the current sociopolitical climate, and particularly in the aftermath of terrorist attacks perpetrated around the world by radical Muslims that proliferate Islamophobia, religious stigma research has concentrated on anti-Muslim (and relatedly, anti-Arab) sentiment and actions. Unfortunately, this appears to have been to the exclusion of producing psychological investigations into the impact of religious-based stigma among other religious groups (e.g., Hindu practitioners) in the United States, as a

comprehensive review of the literature revealed a dearth of information in this area. As such, the inclusion of the Hindu community in the current research was an important next step in exploring the role of stigma, more generally, and religious-based stigma among refugee or immigrant groups, specifically.

Multiple stigmatizing attributes (or multiple stigmas). Some authors speculate that possession of multiple stigmatizing attributes may result in a layering of stigma, imposing a double (or triple, etc.) burden (Duffy, 2005; Mill, 2001; Mill et al., 2009; Mill et al., 2010; Reidpath & Chan, 2005; Weiss & Ramakrishna, 2001) that has been described as an additive effect of multiple stigmatizing attributes (Cole, 2009). Depending on a variety of demographic factors, such as race, ethnicity, religion, and sex, among others, refugees have the potential to possess multiple stigmatizing attributes concurrently. For example, the Somali Bantu, an ethnic minority in Somalia, upon resettlement in a predominately White region in the U.S. possess a racial stigma (Black or African race), an ethnic stigma (Bantu ancestry and language), and a religious stigma (Muslim faith), in addition to the stigma of alien immigration (or foreigner) status; among Somali Bantu women and girls, female sex adds yet another stigmatizing attribute.

Multiple stigmatizing attributes and psychological well-being. Although there are no existing studies focusing on the impact of multiple stigmas on refugee mental health, the literature on HIV-related stigma serves as a model for understanding the complexity of multiple stigmas in the refugee population. It has been said that HIV represents a “peculiarly stigma-sensitive” (Novick, 1997, p. 54) condition given that the preponderance of people with HIV also encounter stigmatization based on other pre-infection identity characteristics (e.g., sexual minority, racial/ethnic minority, IV drug

user, sex worker, low socioeconomic status; Herek & Glunt, 1988; Mawar et al., 2005). Similar to the HIV-positive population, refugees, too, are in the unique position of holding multiple stigmatizing attributes more often than not.

Both qualitative and quantitative studies addressing HIV-related stigma highlight the possibility of an additive negative impact of multiple stigmas. For example, a number of qualitative studies suggest a compounded effect of multiple stigmas among HIV-positive people who are also racial/ethnic minorities (Bogart et al., 2007; Mill et al., 2009, 2010), women (Bogart, Cowgill, Kennedy, Ryan, Murphy, Elijah, & Schuster, 2007; Mill et al., 2009), men who have sex with men (MSM; Bogart et al., 2007), IV drug users (Bogart et al., 2007; Mill et al., 2010), and economically disadvantaged (Mill et al., 2010). Quantitative studies have also shown an association of HIV-related stigma with increased depressive symptomatology among African Americans (Galvan, Davis, Banks, & Bing, 2008; Vyavaharkar et al., 2010) and MSM (Dowshen, Binns, & Garofalo, 2009), as well as greater psychological dysfunction in Latinos (Larios, Davis, Gallo, Heinrich, & Talavera, 2009). In one study of Asians and Pacific Islanders, HIV-related stigma prospectively predicted increases in psychological distress (i.e., depressive and anxious symptoms; Kang, Rapkin, & DeAlmeida, 2006). Together, these findings support an additive or linear effect of multiple stigmatizing attributes, with psychological distress increasing as a function of increasing number of stigmatizing attributes.

However, some research suggests otherwise. For example, in one study, Black and Puerto Rican adults co-infected with HIV and HCV hierarchically ordered their diseases, indicating that they viewed HIV as more stigmatizing than HCV (Lekas, Siegel, & Leider, 2011). Likewise, when compared to Latinos, African American MSM reported

greater stigma related to sexual orientation, whereas Latino MSM reported more HIV-related stigma than African Americans (Wohl et al., 2012). Further, preliminary research by this author (Baptiste, 2014) testing an additive model of multiple stigmas among HIV-positive individuals found that psychological symptomatology did not increase linearly as a function of increasing stigmas. Additionally, when analyses focused on a direct comparison between individuals with only one stigmatizing attribute (HIV) and those with HIV and at least one more stigma, results showed that increasing stigma is related to increased depression and interpersonal sensitivity when controlling for adaptive coping. These findings suggest that the effect of multiple stigmas on mental health outcomes may not be linear; but rather, it may be that as the number of stigmatizing attributes increase, psychological distress increases, but only to a point. For example, it is possible that a significant and clinically meaningful difference exists between individuals with one stigmatizing attribute as compared to those with two or more stigmas, but that there is no observable difference between two and three stigmas (or between three and four, etc.).

These findings are in line with the theory of intersectionality, which views the various components of social identity (e.g., race, sex) as *interdependent*, *interactive*, and *mutually constructed* (Bowleg, 2013; Collins, 2000; Crenshaw, 1989). Thus, intersectionality argues against a linear effect of increasing stigmas, instead predicting interactions between various stigmatizing attributes. Bowleg (2013) has described intersectionality using the metaphor of baking a cake: the ingredients are blended together, after which they “are inextricably combined such that they cannot be separated and reconstituted into their original individual components” (Baptiste, 2014, p. 25). Thus, intersectionality explains curious social phenomena, “such as when the advantages of

being male are obscured by the detriments of being Black or when White privilege dissolves from the disadvantage of poverty” (Baptiste, 2014, p. 25). Theories on intersectionality, in combination with results from our study of people with HIV (Baptiste, 2014), allude to the insufficiency of viewing stigmatizing attributes as independent constructs; rather, it may be more prudent to consider multiple stigmatizing attributes as they relate to and interact with one another. Although some confusion still exists as to the manner by which multiple stigmas operate, researchers contend that “...stigma is experienced differently by people with additional stigmatized identities” (Henkel, Brown, & Kalichman, 2008, p. 1596). As such, some authors (Earnshaw et al., 2013) have implored researchers to examine the role of multiple stigmatizing attributes in order to more fully comprehend the impact of stigma on psychological well-being.

The Present Study

The extant literature overwhelmingly supports higher rates of psychological distress and dysfunction among refugees (for a review, see Fazel et al., 2005; Porter & Haslam, 2005), especially women (for a review, see Porter & Haslam, 2005), those with severe pre-migration trauma experiences (Birman & Tran, 2008; Ichikawa et al., 2006; Mollica et al., 1998; Schweitzer et al., 2011; Schweitzer et al., 2006), and torture survivors (for a review, see Steel et al., 2009). A growing body of research has shown a relation of post-migration living difficulties to refugee mental health (Gerristen et al., 2006; Goodkind et al., 2013; Miller & Rasmussen, 2010; Schweitzer et al., 2011; Schweitzer et al., 2006). One type of post-migration living difficulty that is pervasive in the lives of refugees after securing resettlement and which has been relatively ignored in the refugee literature is stigma. This is surprising given that (1) so many refugees enter

their resettlement communities as minorities, first as non-nationals, and then as ethnic, racial, and religious minorities; and (2) that stigma has long been known to have deleterious effects on psychological well-being (for a review, see Link & Phelan, 2001).

Notably, many refugees possess multiple stigmatizing characteristics concurrently (e.g., minority race, ethnicity, and religion). Moreover, almost half of all refugees are female (UNHCR, 2013). Given the scope of the refugee crisis and current politics, it is imperative to explore this little researched area and to examine how multiple stigmas function in relation to mental health outcomes. As in the general stigma literature, research demonstrates a negative influence of multiple stigmas on mental health. Whereas some researchers have reported an additive effect of multiple stigmatizing attributes on psychological outcomes (Bogart et al., 2007; Dowshen et al., 2009; Galvan et al., 2008; Kang et al., 2006; Larios et al., 2009; Mill et al., 2009, 2010; Vyavaharkar et al., 2010), this finding has not been consistently supported across the literature, perhaps suggesting a non-linear effect. Consequently, more research is needed to clarify the relation between multiple stigmas and psychological well-being.

Given the dearth of research on the effects of stigma on the psychological health of refugees, the present study sought to examine the association between the post-migration living difficulty of stigma and psychological well-being in a sample of refugees of mixed ethnic origins. Specifically, stigma related to race, sex, and religion were explored. A series of three separate sets of analyses were conducted.

Primary Analyses

Testing hypotheses 1a and 1b. First, the present research examined the unique and independent effect of race on mental health outcomes. Of particular interest was the

contribution of race to psychological well-being above and beyond other research-supported correlates of refugee mental health, such as sex and torture history. Second, analyses investigated group differences based on race through a direct comparison of refugees across two racial categories: (1) Black or African ancestry (e.g., from Somalia, Congo, Sudan) and (2) Asian ancestry (e.g., from Bhutan/Nepal, Myanmar/Burma). Given research findings that skin color (light versus dark) impacts outcomes across many indices (for a review, see Hunter, 2007), group differences based on race were expected, as, on average, people of African descent are perceived to be darker-skinned than people of Asian ancestry.

Testing hypothesis 2. As previously noted, in addition to minority race, refugees typically experience stigmatization due to other characteristics, including minority religion. Moreover, females constitute 50% of all refugees. Therefore, an investigation of stigma in a refugee population would be remiss not to explore the relation of multiple stigmas—specifically, race, sex, and religion—to psychological functioning. A number of studies using both qualitative and quantitative methodologies have reported an additive effect of multiple stigmatizing attributes on psychological well-being, with psychological distress increasingly linearly as the number of stigmatizing attributes increases (Bogart et al., 2007; Dowshen et al., 2009; Galvan et al., 2008; Kang et al., 2006; Larios et al., 2009; Mill et al., 2009, 2010; Vyavaharkar et al., 2010). Accordingly, the present research examined an additive model of the impact of multiple stigmatizing attributes on psychological outcomes among refugees of African, Asian, and White/Caucasian ancestry.

Exploratory Analyses

Given the inconsistencies within the literature on multiple stigmatizing attributes, with some studies supporting an additive effect of multiple stigmas on psychological well-being and others supporting interactions between variables, the current study sought to further understanding of the intersectional nature of identity and its impact on mental health outcomes. As such, the sample was partitioned along one dimension of identity (e.g., race) to examine between-group differences along a second dimension of identity (e.g., religion) and vice versa. Thus, exploratory analyses tested the impact of race (African, Asian, White/Caucasian) among Muslims and the effect of religion (Christianity, Hinduism, Islam) among Asians.

Hypotheses

Hypotheses for primary analyses.

Hypothesis 1a. Given the literature on the relation between stigma and psychological well-being, it was hypothesized that racial stigma would make a unique contribution to psychological well-being (i.e., anxiety, depression, and PTSD) independent of the effects of sex and torture history.

Hypothesis 1b. Given the literature on colorism that relates darker skin to poorer outcomes, it was hypothesized that African participants would have higher mean scores for anxiety, depression, PTSD, and total symptoms than Asian participants.

Hypothesis 2. Given the literature supporting intersectionality, it was hypothesized that psychological distress would increase with increasing number of stigmas, but that the relation between multiple stigmas and outcomes would be non-linear.

Exploratory analyses. Exploratory analyses tested the effect of race (African, Asian, White/Caucasian) among Muslims and the effect of religion (Christianity, Hinduism, Islam) among Asians. Given the exploratory nature of the analyses and the scarcity of relevant literature, predictions about effects are not presently offered.

Chapter 3: Methods

Data for the current study were culled from a larger clinical research and service program, Connecting Cultures, at the University of Vermont (Fondacaro & Harder, 2014). At present, over 200 adults receiving psychological or social work/case management services from the Connecting Cultures program have been invited to participate in the research project. Of these, 157 have given consent to participate in the research component of the program. Participant recruitment is ongoing. Data collection occurs at multiple time points, with each participant completing measures at clinical intake, mid-treatment, and termination of services. The current research was restricted to baseline data collected at the time of clinical intake from consenting adult participants.

Participants

Recruitment. Referrals for psychological or social work/case management services primarily included direct requests from community-based organizations serving refugees and asylum-seekers (e.g., the Vermont Refugee Resettlement Program, the Association of Africans Living in Vermont, and the Somali-Bantu Community Association) and local healthcare and social service providers and agencies (e.g., University of Vermont Health Network, Community Health Centers of Burlington, VT Department of Children and Families). Upon consenting to receive services through Connecting Cultures, each client was also offered the opportunity to provide consent to participate in the program's research activities. All individuals seeking services through Connecting Cultures were eligible to participate in the research study.

Sample characteristics. The sample was comprised of 157 adults who sought psychological or social work/case management services through the Connecting Cultures

program at any point from August 2007 to March 2016. Ten participants were omitted from the analyses, including immigrants who did not enter the U.S. as refugees or asylum-seekers, participants whose racial identity could not be categorized into one of the groups of interest (African, Asian, or White/Caucasian), and individuals whose religious affiliation constituted an extremely small minority within the sample (Agnostics, Atheists, Buddhists). Demographic data ($N = 147$) are presented below.

A majority of the sample ($N = 147$) were designated as refugees or former refugees (72.8%; $n = 107$) at the time of clinical intake; whereas the remainder reported their immigration status as permanent residents of the U.S. (1.9%; $n = 16$); asylum-seekers, asylees, or former asylees (7.5%; $n = 11$); or U.S. citizens (7.5%; $n = 11$). Demographic characteristics describing the sample appear in Table 1. Approximately 40% of the sample (39.5%; $n = 58$) identified Bhutan or Nepal as their country of origin and an additional 22.4% ($n = 33$) originated from Somalia. The sample included Muslims (42.2%; $n = 62$), Hindus (33.3%; $n = 49$), and Christians (24.5%; $n = 36$). On average, participants were 43.69 years of age ($SD = 13.06$) and evenly split between males and females (both: 49.7%; $n = 73$). The majority of participants (78.9%; $n = 116$) had lived in a refugee camp prior to resettlement. Of the total sample, 85% (98.43% of those reporting; $n = 125$) reported past exposure to at least one traumatic event; two individuals (1.4%) reported no trauma exposure and 13.6% ($n = 20$) had missing data related to trauma exposure. Across the sample, 72.8% ($n = 107$) of participants reported a torture history.

Procedures

Participants completed the research protocol either at the Connecting Cultures outpatient clinic or at an affiliated community organization. Written consent was obtained for the use of participants' clinical assessments in research. The research measures were administered by a clinician in English via interview format, with interpretation in the participant's native language provided by an interpreter as necessary. All study procedures have been approved by the University of Vermont's Institutional Review Board.

Measures

Demographic survey. Demographic data was obtained from a 21-item survey designed by the research team for the purpose of collecting information including participants' age, sex, race/ethnicity, country of origin, immigration status, date of arrival in the United States, religious affiliation, and torture experiences. This information provided data for key variables under examination, including participants' sex, race, religion, and torture status (i.e., torture survivor versus refugee without a torture history).

Race. Racial classification was made using participants' self-reported information obtained via the demographic survey. In order to preserve statistical power, participants of different ethnic backgrounds were grouped based on the larger dimension of race, allowing for inter-group comparisons. Participants were assigned to one of three racial categories: Black or African, Asian, and White or Caucasian. Racial designations were made based on participants' responses to a question about country of origin (given that direct measurement of race was omitted). Individuals who reported a Sub-Saharan African country (e.g., Somalia, Sudan, Congo) as their country of origin were designated

as Black or African. Participants who reported a country located in East or South Asia (e.g., Bhutan/Nepal, Myanmar/Burma) were designated as Asian. Those who reported a country in Eastern or Western Europe (e.g., Bosnia, Moldova) or the Middle East (e.g., Iran) as their country of origin were designated as White or Caucasian. Persons who did not fall into one of the three aforementioned racial categories were omitted from analyses.

Sex and religion. The demographics survey provided the data for the categorization of participants' sex and religious affiliation. Participants self-reported how they identify with respect to sex and religious affiliation (if any).

Stigma score. Demographic data served as the basis for determining the number of stigmatizing attributes possessed by each participant, or their stigma score (Baptiste, 2014). The stigma score was calculated by enumerating the number of stigmatizing attributes possessed across race, sex, and religion; and ranges from one to three. Although refugee (or alien immigration) status represents a stigmatizing attribute, for ease of interpretation, immigration status was coded as zero. For each additional stigmatizing attribute, the stigma score was increased by one, as in the case of individuals identifying as a racial minority (African, Asian), a religious minority (Muslim, Hindu), or female. For example, an African or Asian male of Christian faith was assigned a stigma score of one, whereas a Bhutanese female of Hindu faith had a stigma score of three.

Torture status. Torture status was determined via participants' responses to a question about past experiences with torture that asks respondents to choose all applicable items from a checklist of 17 types of torture (e.g., beating, rape or sexual torture, psychological/threats, secondary survivor, other). Further information regarding

participants' torture histories was obtained through administration of the Harvard Trauma Questionnaire (Mollica & Caspi-Yavin, 1991). Any participant indicating one or more types of torture experiences across either measure was categorized as a torture survivor.

Harvard Trauma Questionnaire (HTQ; Mollica & Caspi-Yavin, 1991).

Exposure to traumatic events and trauma-related symptomatology, including PTSD symptoms, was evaluated by the HTQ. The HTQ is a self-report checklist that inquires about a number of trauma events and measures the extent to which respondents have suffered from associated psychological symptoms during the previous week. Part I of the HTQ asks respondents to indicate their exposure to 17 traumatic life events; for each item, participants specify the extent of their exposure, choosing from four possible response options: "experienced," "witnessed," "heard about," or "no." All participants who endorsed having experienced or witnessed one or more traumatic events were classified as having been exposed to trauma.

Part II of the HTQ asks respondents to provide a narrative account of the most traumatic event(s) they have experienced. Data on events with a potential to result in head injury is collected in part III of the HTQ. Part IV of the HTQ consists of 16 items derived from the *Diagnostic and statistical manual of mental disorders* (4th edition, text revision, *DSM-IV-TR*; APA, 2000) criteria for PTSD and 14 items derived from clinical experience with trauma survivors. Participants indicate the extent to which they have suffered from each symptom in the past week using a 4-point Likert scale (0 = "not at all," 1 = "a little," 3 = "quite a bit," 4 = "extremely").

Two scores are provided: the *DSM-IV-TR* PTSD Score represents the average score for the 16 items comprising the *DSM-IV-TR* diagnostic criteria for PTSD, whereas

the Total Score represents an average across all items. Scores meeting or exceeding the cut-off value of 2.5 on either scale indicate clinically significant levels of PTSD symptoms and/or general trauma-related distress in the week prior to administration of the measure. The HTQ was developed for use with and validated in a clinic-based Indochinese population (Mollica et al., 1992). Validation studies of the instrument reported a sensitivity of 78% and a specificity of 65% (for the clinical cut-off score of 2.5; 57), in addition to good test-retest reliability ($\alpha = .89-.92$) and excellent inter-rater reliability ($\alpha = .93-.98$) and internal consistency ($\alpha = .90-.96$) across studies (Friedman & Mikus-Kos, 2005). Since its development, subsequent versions of the HTQ have been used with a wide range of traumatized populations (e.g., Japanese, Bosnians, Croatians).

Hopkins Symptom Checklist-25 (HSCL-25; Parloff, Kelman, & Frank, 1954).

Anxious and depressive symptomatology was assessed using the HSCL-25, a 25-item self-report symptom inventory evaluating current symptoms of depression and anxiety. Respondents rate the extent to which they have been bothered by anxious and depressive symptoms within the last week on a 4-point Likert scale (0 = “not at all,” 1 = “a little,” 3 = “quite a bit,” 4 = “extremely”). Three scores are provided: the *DSM-IV-TR* Depression Score represents the average of the 15 symptoms characteristic of depression; the Anxiety Score corresponds to the affective and somatic expressions of anxiety; and the Total Score represents an average across all 25 items. Scores that meet or exceed the cut-off value of 1.75 on any of the three scales indicate clinically significant levels of anxiety, depression, and/or general distress in the week prior to administration of the measure.

Research across numerous populations has demonstrated a consistent association between the *DSM-IV-TR* Depression Score and the diagnostic criteria for major

depressive disorder laid out in *DSM-IV-TR* and between the Total Score and severe emotional distress of unspecified diagnosis. The HSCL-25 has been well-established as an appropriate measure for use within refugee and asylum-seeker populations, with good to excellent overall internal consistency ratings (α ranges from .91 among West Africans to .96 among Afghans; 60) across numerous populations and languages. Studies have reported Cronbach's alpha coefficients ranging from .83 to .91 for the anxiety scale and from .85 to .92 for the depression scale (Kleijn, Hovens, & Rodenburg, 2001).

Data Analysis

All statistical analyses were conducted using SPSS version 23. There were no missing data across two (torture status, race) of the three demographic variables included as independent variables in the main study analyses and negligible missing data (.7%) across the third variable (sex). However, across the variables comprising the outcome measures (i.e., the HSCL-25 and HTQ), missing data led to scale scores not being calculated in 9.5% to 25.9% of cases. Missing values resulted in part from the omission of an outcome measure in its entirety: 6.12% and 17.01% for the HSCL-25 and the HTQ, respectively (and in 2.72% of cases, both measures). These values increased to 16.3% for individual items on the HSCL-25 (i.e., "loss of sexual interest or pleasure") and to 2.4% for items on the HTQ (i.e., "feeling guilty for having survived"). Data were assumed to be missing at random (Allison, 2000; E. Stuart, Azur, Frangakis, & Leaf, 2009), thus, multiple imputation was deemed appropriate to estimate missing data (Little & Rubin, 1987; Tabachnick & Fidell, 2013). The imputation model included items from the demographic survey, the HSCL-25, and the HTQ. HSCL-25 and HTQ data were imputed. Pooled statistics (representing averages) across 20 imputations are reported.

Analyses were restricted to only those participants who entered the U.S. as refugees or asylum-seekers and whose racial designation and religious affiliation could be categorized along one of the three main racial and religious groups of interest ($N = 147$). All others were omitted from analyses.

Power analyses conducted *a priori* using G*Power version 3.1.9.2 estimated that statistical power would be adequate to detect between-group differences across the main study aims (testing hypotheses 1a, 1b, and 2). Importantly, analyses testing hypotheses 1a and 1b were restricted to a subset of the population representing refugees of African ($n = 56$) and Asian ancestry ($n = 65$). With regards to testing hypothesis 1a, a sample size of $N = 114$ was needed to detect an effect size of .1 (between small and medium effect size), with $\alpha = .05$ and power equal to .80. For follow-up analyses testing hypothesis 1b, a sample size of $N = 119$ would detect a medium effect size (.26), with $\alpha = .05$ and power equal to .80. To test hypothesis 2, a sample size of $N = 100$ was needed to detect an effect size of .1, with $\alpha = .05$ and power equal to .80. As such, it is estimated that statistical power was sufficient given the sample size ($N = 147$), even when analyses were restricted to a subset of the sample ($N = 121$).

Exploratory analyses partitioned the sample even further, limiting analyses to only individuals identifying as Muslim ($n = 59$) and Asian ($n = 65$). To conduct exploratory analyses, a sample size of $N = 64$ is needed to detect an effect size of .4 (large effect size), with $\alpha = .05$ and power equal to .80. Accordingly, exploratory analyses may have been under-powered.

Preliminary analyses. Descriptive statistics, including mean scores and standard deviations, were calculated for all variables in order to characterize the sample. A

correlation matrix was constructed and chi square analyses were conducted to explore relations among the study variables. An examination of the relations between the independent variables (sex, race, religion, torture status) and the outcome variables (anxiety, depression, PTSD, total symptoms) was of particular interest given the research aims.

Primary analyses. General linear model procedures (ANOVA) were utilized to conduct all analyses. Each analysis included one of the five psychological well-being variables (anxiety, depression, PTSD, HSCL-25 Total Symptoms, HTQ Total Symptoms) as the outcome. Two separate sets of analyses were conducted in order to examine the effect of race and the impact of multiple stigmas on refugees' psychological well-being. First, analyses testing the unique and independent influence of race above and beyond sex and torture status utilized ANOVA in two steps: (1) in step 1, sex and torture status were entered as factors; (2) in step 2, sex and torture status were held constant and race was included as a factor. White participants were omitted from these analyses to allow for an examination of the effects of colorism through a direct comparison of African refugees to Asian refugees.

The next set of analyses tested whether the relation between multiple stigmatizing attributes and psychological well-being is linear. The stigma score was coded as discussed above in order to allow the y-intercept to be interpreted as the score for White/Caucasian Christian males. Five separate regression and ANOVA analyses were conducted. The regression analyses included the stigma score as an ordinal variable, whereas the ANOVA relied on the stigma score entered as a single factor with one of the psychological well-being variables (anxiety, depression, PTSD, HSCL-25 Total

Symptoms, HTQ Total Symptoms) as the dependent variable. Analyses included participants across all three racial categories under investigation (African, Asian, White/Caucasian).

Exploratory analyses. The final set of analyses investigated the function of one dimension of identity (e.g., race) on another facet of identity (religion) within a subset of the sample (e.g., Muslims) in an attempt to advance our knowledge of relationships between stigma and psychological well-being in persons with multiple stigmatizing attributes. Two series of analyses were run consecutively, each with one of the psychological well-being variables (anxiety, depression, PTSD, HSCL-25 Total Symptoms, HTQ Total Symptoms) serving as the outcome across five ANOVA analyses. Covariates and factors to be held constant were identified through correlation analyses and included as appropriate. The stigma variable under investigation (e.g., religion or race) was entered as a fixed factor.

Chapter 4: Results

Preliminary Analyses

Demographic characteristics describing the sample appear in Table 1. Table 2 presents descriptive statistics and bivariate correlations for all continuous variables. Additional correlation analyses were conducted on subsets of the sample (e.g., Africans and Asians, Muslims, Asians) in order to identify variables to hold constant when testing between-group differences (hypothesis 1b and exploratory analyses).

Within the current sample, reliability analyses yielded good to excellent internal consistency ratings for both outcome measures. Across the scales of the HSCL-25, Cronbach's alpha coefficients ranged from .90 for the Depression Score and the Anxiety Score to .94 for the Total Score. Cronbach's alpha coefficients were .88 and .92 for the HTQ PTSD Score and the HTQ Total Score, respectively.

As would be expected, each of the five outcome variables were significantly and positively correlated with each other (see Table 2), indicating that increased psychological symptomatology in one domain (e.g., depression) is related to greater symptomatology in other areas, both across clinical syndromes (e.g., anxiety, depression, PTSD), and generally, across total symptoms (e.g., HSCL-25 Total Score and HTQ Total Score).

Furthermore, the same is true for individuals whose scores met or exceeded the threshold for clinical significance, as scores on the clinical cut-off variables were all positively and significantly correlated with each other ($ps < .05$), suggesting that meeting or exceeding one clinical threshold (e.g., anxiety) increases one's likelihood of meeting

or exceeding clinical thresholds across all other domains (i.e., depression, PTSD, total symptoms).

A majority of the sample met or exceeded the HSCL-25 clinical cut-offs ($p < .05$), indicating that on average, participants were experiencing clinically significant levels of anxiety (69%), depression (70%), and total symptoms (72%). On the contrary, a majority of participants did not meet/exceed the clinical thresholds for PTSD (38%) or HTQ Total Score (30%), indicating that on average, the sample displayed subclinical levels of posttraumatic stress symptomatology.

With respect to the main outcomes, chi square analyses results revealed significant relations between religion and depression scores ($\chi^2(1, N = 147) = 101.80, p = .048$) and between immigration status and anxiety scores ($\chi^2(1, N = 147) = 147.25, p = .04$). In addition, a number of variables were related to meeting or exceeding clinical significance thresholds across the outcome variables. Sex ($\chi^2(1, N = 147) = 4.48, p = .04$) and immigration status ($\chi^2(1, N = 147) = 11.69, p = .02$) were related to meeting or exceeding the clinical significance threshold for anxiety; sex ($\chi^2(1, N = 147) = 5.20, p = .03$), race ($\chi^2(1, N = 147) = 8.15, p = .02$), and religion ($\chi^2(1, N = 147) = 14.89, p = .001$) were related to clinically significant depressive symptoms; sex ($\chi^2(1, N = 147) = 5.17, p = .03$) and religion ($\chi^2(1, N = 147) = 10.76, p < .01$) were significantly related to clinical levels of general symptoms (HSCL-25 Total); religion sex ($\chi^2(1, N = 147) = 9.60, p = .01$) and immigration status sex ($\chi^2(1, N = 147) = 11.54, p = .03$) and religion ($\chi^2(1, N = 147) = 10.76, p < .01$) were related to clinically significant PTSD symptomatology.

Primary analyses.

Hypothesis 1a. ANOVA in two steps was used to test the hypotheses that race would exert a unique effect on psychological well-being independent of sex and torture status (hypothesis 1a) and that African refugees would have higher mean scores for anxiety, depression, PTSD, and total symptoms than Asian refugees (hypothesis 1b). With one of the psychological well-being variables (anxiety, depression, PTSD, HSCL-25 Total Score, HTQ Total Score) as the outcome, sex and torture status were entered as factors in step 1 of the analyses. Race was included as a factor in step 2. Analyses were limited to African and Asian participants (White/Caucasian participants were omitted; $n = 121$). Across the models testing the effects of sex and torture status on outcomes (step 1), results indicated that neither sex nor torture status had a significant effect on anxiety, HSCL-25 Total Score, PTSD, or HTQ Total Score ($ps > .05$; see Table 3). Results demonstrated a significant effect of sex on depression ($F(1, 118) = 6.12, p = .02, \eta^2 = .05$) when controlling for torture status; the effect of torture status was non-significant ($p > .05$). Pairwise comparisons revealed significant between-group differences ($p = .02$), with females ($EMM = 2.33, SE = .13$) reporting higher levels of depressive symptoms than males ($EMM = 2.00, SE = .13$).

Step 2 included race as a factor, with sex and torture status held constant.

Consistent with the findings from step 1, women ($EMM = 2.33, SE = .14, F(1, 117) = 5.13, p = .03, \eta^2 = .04$) obtained higher depression scores than men ($EMM = 2.03, SE = .13, p = .03$) after adjusting for torture status and race; torture status was not significantly related to depression scores when adjusting for sex and race ($p > .05$). Results showed no effect of sex or torture status on anxiety, HSCL-25 Total Score, PTSD, or HTQ Total

Score ($ps > .05$) after the inclusion of race in the models. Across both scales of the HTQ, a significant between-groups effect of race was found for PTSD ($F(1, 117) = 7.79, p < .01, \eta^2 = .06$; see Table 4) and HTQ Total Score ($F(1, 117) = 6.36, p < .01, \eta^2 = .05$) when controlling for the effects of sex and torture status. Pairwise comparisons indicated that Africans reported higher levels of PTSD ($EMM = 2.27, SE = .13$; see Table 5) and total posttraumatic stress symptoms ($EMM = 2.22, SE = .12$) than Asians ($EMM = 1.93, SE = .12$ and $EMM = 1.92, SE = .11$, respectively; $ps = .01$), when holding sex and torture status constant.

Analyses were replicated to include additional factors (per results of the correlation analyses) in the model to account for their effects. Results indicated that between-group differences were not observed when adjusting for immigration status and religion ($ps > .05$).

The data provided partial support for hypothesis 1a, as race significantly predicted PTSD and HTQ Total Score when controlling for sex and torture status ($ps < .05$; see Table 3). Race was not a significant predictor of anxiety, depression, or HSCL-25 Total Score ($ps > .05$); in supplemental analyses adjusting for immigration status and religion, the effect of race on posttraumatic stress symptoms fell out of significance. In addition, these results also provided partial support for hypothesis 1b in that, when racial differences were found, African refugees reported higher scores than their Asian refugee counterparts.

Hypothesis 2. Linear regression and ANOVA were used to test whether the relation between multiple stigmatizing attributes and psychological well-being is linear in a sample of refugees of mixed ethnic/racial origin and religious affiliation. It was

hypothesized that as number of stigmas increased, psychological distress would increase, but that the relation of multiple stigmas to outcomes would not be linear. With one of the psychological well-being variables (anxiety, depression, PTSD, HSCL-25 Total Score, HTQ Total Score) as the dependent variable, stigma score was entered either as a continuous variable (in regression analyses), as a test of a linear relationship, or as a fixed factor (in ANOVA) to examine whether a relationship between the number of stigmas encountered was related to psychological outcomes, but in a manner that was not linear. Simple contrasts for the ANOVA models compared each level of the factor (stigma score) to a reference category representing a stigma score of zero (White Christian Male). Analyses included the full sample ($N = 147$).

Results indicated that stigma score was not related to psychological well-being ($ps > .05$; see Table 6), either when conceptualized as a single continuous variable in the linear regression models, or when considered categorically in the ANOVA models, across all five models. For all outcomes, estimated marginal means for the reference category (stigma score = 0) were consistently lower than the estimated marginal means for all other levels of the factor (i.e., stigma score = 1, 2, or 3; $ps > .05$; see Table 7); however, scores did not increase linearly as number of stigmas increased from one to two and from two to three. Although the lack of statistical significance from the regression model suggests that a linear relationship between the number of stigmas and psychological outcomes does not exist, the similar lack of statistical significance between the number of stigmas and psychological outcomes from the ANOVA model does not allow us to reflect on the potential effect of multiple stigmatizing attributes.

In order to examine the data for a threshold effect, we elected to categorize the stigma score as present or absent, such that the stigma score was coded as one for participants possessing at least one stigmatizing attribute (stigmatized sex, race, and/or religion) or zero (aside from refugee status) in all other cases. This reconceptualization permitted a direct comparison of individuals with zero stigmatizing attributes (beyond refugee status) to those possessing one or more (up to three) stigmas (in addition to refugee status). Table 8 presents the results of the regression of psychological outcomes on number of stigmas (one versus one or more). Results do not support threshold effects of increasing stigmas for any of the outcomes ($p > .05$; see Table 8). Taken together, results do not provide evidence of a relation between increasing number of stigmas and greater psychological symptomatology.

Exploratory analyses.

Effect of race among Muslims. Exploratory analyses were conducted via the general linear model (ANOVA) to investigate the between-group effect of race (African, Asian, White/Caucasian) on mental health symptomatology among Muslim participants ($n = 59$). Demographic variables previously identified as correlated with outcomes were entered as covariates and factors as appropriate. Results showed no significant differences between racial groups in the Muslim subset of the sample across all five psychological outcomes ($p > .05$; see Table 9).

Effect of religion among Asians. Exploratory analyses examined between-group effects of religion on psychological outcomes among Asian participants ($n = 65$) using ANOVA. Results showed a significant between-groups effect of religion on HSCL-25 Total Score ($F(2, 62) = 3.65, p = .03, \eta^2 = .11$; see Table 10) and HTQ Total Score

among Asians ($F(2, 62) = 2.63, p = .04, \eta^2 = .10$). Bonferroni corrected pairwise comparisons conducted as a follow-up were non-significant ($p > .05$) for both HSCL-25 Total Score and HTQ Total Score; however, mean group differences between Muslim Asians and Hindu Asians approached significance ($p = .07$), with Muslims ($M = 2.42, SD = .60$) reporting higher general posttraumatic stress symptoms than Hindus ($M = 1.88, SD = .56$). No between-groups effects were found for anxiety, depression, or PTSD ($ps > .05$).

Chapter 5: Discussion

Summary of Results

The present study examined the impact of stigma on psychological well-being in a sample of resettled refugees of mixed ethnic/racial and religious origins. Specifically, analyses tested (1) the independent effect of race among African and Asian refugees, (2) a linear model of multiple stigmas predicting mental health outcomes in a sample of refugees of mixed ethnic/racial and religious composition, and (3) between-group effects of race among Muslims and of religion among Asian refugees. Results furnished partial support for hypotheses 1a and 1b. Findings are discussed below.

Independent effect of race on psychological well-being.

Race and psychological well-being of African and Asian refugees. Results provided partial support for the hypothesis that race would exercise a significant and independent effect on psychopathology as compared to other research-supported correlates (e.g., sex and torture status) as findings showed a significant effect of race on African and Asian refugees' posttraumatic stress responses (PTSD and HTQ Total Score) after controlling for sex and torture status. Specifically, African refugees exhibited higher levels of posttraumatic stress symptoms than Asians. Race was not a significant predictor of depression or HSCL-25 Total Score when accounting for sex and torture status. When adjusting for immigrant status and religion, race no longer significantly predicted posttraumatic stress symptomatology, which may be due to insufficient power to detect a small effect in the expanded model, multicollinearity between the race and religion variables, or a suppression effect of having controlled for confounding variables (Tu, Gunnell, & Gilthorpe, 2008).

These results point to differences between African and Asian refugees irrespective of sex and/or torture status, which may suggest an impact of colorism (see Hunter, 2007) on posttraumatic stress symptomatology within the African and Asian refugee population. Colorism operates to privilege individuals with lighter skin tone for more closely approximating a White ideal than those with darker skin color (Burke & Embrich, 2008; Hunter, 2005, 2007); and, in so doing, perpetuates differentiation and inequalities within and among racial groups (Burton et al., 2010). Colorism, then, may represent how race-related stigma functions practically: not simply separating people based on deviation from the White archetype into a global in-group (White) and out-group (all others), but also into sub-groups within the out-group indicating degree of difference and, consequently, degree of stigmatization. As such, the finding that African participants exhibited higher mean scores for posttraumatic stress symptoms than Asians may be explained by the increased level of stigma associated with black skin. Moreover, the minority stress model (Meyer, 1995, 2003) posits that in addition to perceived stigma (i.e., cognizance of negative societal beliefs, feared and anticipated social rejection) and enacted stigma (overt discrimination) experienced by minorities, internalized stigma—or the acceptance of negative evaluations toward one’s social group and self—poses chronic stress to the individual (Herek, Gillis, & Cogan, 2009; Meyer, 1995). Perhaps Africans have internalized societal messages reflecting colorism and their respective social standing in the skin color hierarchy, thus accounting for the higher level of reported posttraumatic stress symptoms as compared to their Asian counterparts.

These findings are particularly interesting given that the same effect was not observed for anxiety, depression, or HSCL-25 Total symptoms. In interpreting these

results, it is critically important to remember how a refugee comes to be a refugee. Refugee status is predicated upon a demonstrable history or well-founded fear of persecution (verified by extensive investigations by UNHCR and U.S. government agencies) due to membership in one of five protected categories, of which four relate to an aspect of one's identity: race, religion, nationality, and membership of a particular social group (the fifth eligible category is political opinion; UNHCR, 2015d). In this way, refugees have already experienced considerable trauma and stigmatization far prior to resettlement; moreover, it is likely that their pre-migration trauma experiences relate directly to identity-based (e.g., race, religion, sex) stigmatization, in which case stigma and trauma are inextricably linked. Some authors (Loo, C., Singh & Scurfield, R., & Kilauano, 1998; Loo, 1994) have conceptualized race-related threats of injury or death as meeting the definition of a qualifying event for a PTSD diagnosis (see American Psychiatric Association, 2000) and have proposed the experience of racist events as an important risk factor for developing PTSD (Loo et al., 2001), with exposure to cumulative racism experienced as traumatic (Loo, 1994). Refugees' pre-resettlement experiences with chronic minority stress (Meyer, 1995, 2003) and related trauma may be compounded by confronting further or new stigmatization in their resettlement communities, resulting in increased posttraumatic stress.

Studies spanning at least two decades have established a connection between race-related stigma and posttraumatic stress symptoms. Research supports an association between overt race-related stigmatization (i.e., race-motivated assault) and increased posttraumatic symptomatology, both in the immediate and eventual aftermath of the racist event (Carter, 2007). Furthermore, studies of Asian-American Vietnam veterans

provide additional evidence of a relation between race-based stigma and PTSD that is especially relevant to refugees, as refugees are often exposed to war-like conditions, if not combat itself. Separately and together, exposure to a racist environment, perceived racial stigmatization and prejudice, and bicultural identification and conflict predicted PTSD and general symptomatology above and beyond combat exposure and military rank, increasing the amount of variance explained by 19% to 20% (Loo et al., 2001). Additionally, in large scale epidemiological studies, researchers have linked higher levels of perceived discrimination to greater PTSD symptom severity and increased likelihood of receiving a PTSD diagnosis (Chou, Asnaani, & Hofmann, 2012; Pole, Gone, & Kulkarni, 2008). Asnaani and Hall-Clark (2017) describe perceived ethnic/racial discrimination as a significant factor maintaining PTSD and other trauma-related sequelae. As such, the results showing differences in posttraumatic stress symptomatology between African and Asian refugees are unsurprising. Further analyses are necessary to provide a strong evidentiary basis for the effect of colorism on posttraumatic stress symptoms of resettled African and Asian refugees.

Race and psychological well-being of Muslims. Among Muslims, no significant race differences were found (for any of the outcomes), indicating that in our sample, Muslim refugees experienced equivalent levels of psychopathology across racial groups. Individually (by race) and on the whole, Muslims exceeded clinical thresholds for anxiety, depression, and HSCL-25 Total Score. The non-significant finding with respect to race differences among Muslims may be a signpost for a recent and sharp uptick in Islamophobia, with anti-Islamic sentiment trumping the effect of racial stigma. Although Muslims have long experienced stigmatization in the U.S., the post-9/11 era and its

ongoing “war on terror” (Bush, 2001) have seen the intensification of an age-old stigma, with Muslims routinely depicted as fanatical, intolerant, and violent (Perry, 2014). Twenty-six percent of survey respondents reported negative associations with the word, “Muslim,” including slurs and references to hatred, guns, violence, terrorism, and war (Council on American-Islamic Relations, 2006). Perhaps more disturbing was the finding that one-quarter of those surveyed endorsed one or more of the following characterizations: “Muslims teach their children to hate unbelievers,” “Muslims value life less than other people,” and “The Muslim religion teaches violence and hatred” (Council on American-Islamic Relations Research Center, 2006, p. 3). Additionally, 19% of respondents supported restricting Muslims’ civil liberties, including 17% who agreed with jailing Muslims preemptively “just in case they are planning terrorist acts” (Council on American-Islamic Relations Research Center, 2006, p. 5).

The backlash (against both Muslims and those who could be mistaken for Muslim or Arab) has been severe, as hate crimes against Muslims began to rise as soon as 24 hours after the terror attacks of September 11th, with eight such homicides committed in that same period (Perry, 2014). Two months later, over 1100 hate crimes related to the events of 9/11 had been recorded by the American-Arab Anti-Discrimination Committee (Perry, 2014). In mid-November 2016, the Federal Bureau of Investigation released statistics pointing to a swell in hate crimes perpetrated against American Muslims in 2015 (up 67% over 2014, highest since 2001) that drove an overall increase of 6% in hate crimes (e.g., threats, assaults, property destruction, bombings) across all groups (Lichtblau, 2016). In the week following the 2016 U.S. presidential election, hate crimes spiked, with some reporting, “dozens of verbal or physical assaults on minorities and

others that appear to have been fueled by divisions over the election” (Lichtblau, 2016). Stigma is not created in a vacuum, but rather is formed by social context. In contemporary America, to be Muslim is to be feared and reviled. These data highlight the intense stigma currently facing Muslims in America and suggest that religious stigma may be more salient than race-related stigma for Muslims.

Independent effect of sex on psychological well-being. Results indicated that when controlling for torture status and race within an African and Asian sample, sex is significantly related to depressive symptomatology specifically, but not to general affective distress (as measured by the HSCL-25 Total Score) when anxiety symptoms are lumped together with depressive items. Additionally, results showed that among African and Asian refugees, sex is not a significant predictor of anxiety or posttraumatic stress symptoms when controlling for torture status. These results corroborate findings that refugee women do not report higher rates of anxiety (Ayazi et al., 2014; Perera et al., 2013) or PTSD (Steel et al., 2009). As with the mixed results shown in the literature (see Steel et al., 2009 for a review), findings indicated that sex predicts some mental health outcomes (i.e., depression) but not others (anxiety, PTSD, total symptoms) in a refugee sample. Epidemiological studies typically report a two-fold increase in depression rates among women as compared to men; however, these studies rely heavily on Western samples. Some authors (Silverstein, 2002) have noted that a pattern of increased somatic complaints (i.e., sleep disturbances, changed appetite, and fatigue) among women, as compared to men, may account for the consistent finding across the literature that women exhibit much higher rates of depression than men. In this manner, the effect of sex on depression in our sample may be due to uniquely different somatic symptom profiles

among men and women. Furthermore, Perera and colleagues (2013) have suggested that sex may interact with ethnicity to predict psychological well-being in refugee samples. Additional moderation analyses may provide clarification as to the impact of sex on refugee mental health.

Independent effect of torture status on psychological well-being. In our sample, torture status was not a significant predictor of mental health outcomes (both across the total sample and when partitioning the sample into subsections). These results contradict prior findings on the impact of torture history on depression (see Rončević-Grzeta et al., 2001; Shrestha et al., 1998; Steel et al., 2009). Given that our sample was drawn from a clinical population seeking psychological or social work services, it is possible that our participants represent an extreme segment of the refugee population displaying greater psychopathology than the refugee community at large. In fact, the sample was imbalanced toward torture survivors, with 73% of the sample reporting a torture history. In light of previous research indicating that women (Bogic et al., 2012; Gerristen et al., 2006; Porter & Haslam, 2005) and torture survivors (Rončević-Grzeta et al., 2001; Shrestha et al., 1998; Steel et al., 2009) report greater symptomatology than men and individuals without a torture history, perhaps it is the case that among those reporting the highest levels of psychopathology, the influence of sex and torture status is diminished.

Effect of multiple stigmatizing attributes on psychological well-being. Consistent with our hypothesis, a linear relation between multiple stigmas and psychopathology was not observed. Psychological outcomes did not worsen as number of stigmatizing attributes increased; neither were there threshold effects. It is possible that

this finding reflects a true lack of effect. Alternatively, it is plausible that the current analyses lacked sufficient statistical power to detect the true effect of multiple stigmas on mental health outcomes or that the relation is non-linear. Thus, results provide a rationale for exploring more complex models of stigma that test non-linear effects and interactions among variables.

Effect of religion on psychological well-being of Asian refugees. Results of exploratory analyses indicated a significant between-groups effect of religion on the general posttraumatic stress symptomatology of Asian refugees. Bonferroni corrected pairwise comparisons between Muslim Asians and Hindu Asians approached significance. This discrepancy may be due to loss of statistical power associated with use of the Bonferroni correction to control familywise error (Field, 2013). In this case, results suggest that Muslim Asian refugees may experience a higher level of general posttraumatic stress symptomatology than their Hindu counterparts, perhaps owing to the higher level of stigmatization encountered by Muslims (Fox & Akbaba, 2015). This conclusion is in line with previously discussed findings of equivalent and high levels of posttraumatic stress symptoms among Muslims irrespective of race. No between-groups effects were found for anxiety, depression, or PTSD. Recent research comparing Muslims and Hindus reported no differences in well-being or mental health; however, the study was limited by small sample size and relied on a single measure of mental health comprised of 12-items and yielding a single total score (Magan, Siddiqi, & Shafiq, 2016). Given the scarcity of research investigating differences between Muslims and Hindus with respect to psychological well-being, these results underscore the importance of furthering this line of research.

Limitations

The results of the current study must be interpreted and understood within the context of several limitations. First, the cross-sectional and correlational nature of the research design precludes any causal conclusions. Secondly, our sample was comprised of a clinic-referred population of treatment-seeking refugees, suggesting that results may not generalize to the refugee community at-large or to other (non-refugee) populations. In particular, our results may reflect ceiling effects as refugee classification, by nature, encompasses extreme circumstances. Additionally, torture survivors have experienced unparalleled persecution and trauma beyond the already horrific refugee experience. Indeed, across the sample, which was comprised of 73% torture survivors, mean anxiety, depression, and HSCL-25 Total scores far exceeded clinical thresholds, indicating that on the whole, refugees exhibit high rates of psychopathology. On the contrary, a majority of participants did not meet/exceed the clinical thresholds for PTSD or HTQ Total Score.

Generalizability is also limited by the ethnic homogeneity of the sample, which was largely comprised of individuals from either Bhutan/Nepal or Somalia. This lack of heterogeneity may also have increased the amount of shared variance between race and religion as the majority of Somali participants identified as Muslim, whereas the majority of Bhutanese/Nepali identified as Hindu. As such, the distinction between race and religion may not have been pure.

Moreover, a number of limitations relate to measurement. All data were obtained via self-report instruments, which are inherently subject to certain types of bias (e.g., errors in reporting, faking good or bad to present oneself in a desired light, shared variance). Although designed to be completed in English by the participants themselves,

given the language barrier and lack of formal education/low literacy, all measures were administered via interview format in English with oral interpretation provided in the participant's native language. When possible, word-for-word interpretation was provided, but in other cases, when a word or idiom was not well understood, items were slightly altered to enhance understanding (e.g., "feeling blue" interpreted as "feeling sad"). Accordingly, validity may have been compromised through the interpretation process. Additionally, given the incredibly private and sensitive nature of trauma, torture, and mental health symptoms, it is possible that participants were hesitant to reveal details about their past trauma/torture experiences and present symptoms, especially during early meetings with a new clinician, in which case, our estimates might be an underrepresentation of the true prevalence.

Further, the present study analyzed data gathered through intake and assessment procedures related to direct service mental health activities. As such, the measures did not assess perceptions of stigma, overt experiences with stigmatization and discrimination, or internalized stigma. Instead, demographic data was used as a proxy for stigma. Additionally, the race variable was then computed by assigning a racial designation based on participants' reported country of origin. Similarly, race was viewed as an analogue for skin color in order to examine colorism between African and Asian refugees. The lack of direct measurement of these variables may have led to an obscuring of the nuances of these constructs, limiting the interpretations possible.

Close inspection of the HSCL-25 anxiety scale indicated that the items comprising this score primarily represent somatic (e.g., trembling, headaches) and affective symptoms (e.g., suddenly scared for no reason, feeling fearful), whereas the

cognitive aspect of anxiety (e.g., worry) is absent. Eight of the ten items that constitute the anxiety score can be categorized as either somatic or a combination of somatic and affective symptoms; the remaining two items are affective. In effect, the anxiety outcome variable may be more accurately described as a somatic anxiety scale. To accurately assess clinically significant anxiety, measurement of the cognitive element of worry is critical.

Finally, due to sample size restrictions, results may have been limited due to lack of statistical power. For example, *a priori* calculations of power indicated that the recruited sample size ($N = 147$) would be sufficient to detect a small to medium-sized effect across the main analyses, but would not be sufficient to detect a small effect. The exploratory analyses stretched the limits of statistical power further by testing a subset of the sample (Muslims only, $N = 59$; Asians only, $N = 65$). Accordingly, exploratory analyses may have been under-powered.

Implications and Future Directions

Findings related to race and religion. Given the findings related to the effects of race and religion on posttraumatic stress symptoms, the use of culturally appropriate interventions to treat refugees is critically important. These results, in combination with the extant literature, direct clinicians to treat social stigma alongside what has traditionally been viewed as trauma. Thus, for treatments to be maximally effective, it is incumbent upon interventionists to actively seek not to replicate the hostile environment of the outside world within the therapy room. Therapy interactions spoiled by microaggressions, or “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile,

derogatory, or negative... slights and insults to the target person or group,” (Sue et al., 2007, p. 271) obstruct clients’ ability to engage in treatment. Services that lack contextual cultural factors breed cultural mistrust and prompt client disengagement, including missed appointments and premature termination (Mazzula & Nadal, 2015). Clinicians are called upon to examine their own identities, beliefs, and biases in context given that they, too, are products of the same social environment that produces the social stigma minorities face. The present findings provide further basis for developing culturally appropriate contextual services for diverse populations, particularly given traditionally low mental health services utilization among people of color (Carter & Forsyth, 2010), refugees (Weine et al., 2000), and Muslims (Inayat, 2007) despite high need.

Future research is needed to probe the effects of race and religion on psychological well-being among refugees, especially as effects were not observed across all outcomes. Recruitment of a large and ethnically/racially heterogeneous sample is recommended. Notably, the original recruited sample included 10 Buddhist participants whom were omitted from analyses due to their small number relative to the other groups and overall sample size. In so doing, we were unable to explore an interesting comparison between the four religions represented by our Asian sample. Going forward, concerted recruitment efforts should be made to target this group and allow for a comparison of Buddhists to Christians, Muslims, and Hindus.

Importantly, studies of religious groups should be flexible enough to model religion as both a risk factor and a protective factor. Similarly, researchers would do well to measure ethnic/racial identification and acculturation among refugees in order to investigate internal processes as they relate to refugees’ experience of stigma. Lastly,

future research that examines the impact of caste systems on resettled South Asian refugees is greatly needed as participants in this study reported anecdotally on the continued ramifications of caste designations in everyday life, including group therapy dynamics.

Findings related to sex. Importantly, men constituted 50.7% of our sample, which is atypical, given low psychotherapy help-seeking rates among males (Hammer, Vogel, & Heimerdinger-Edwards, 2013; Oliver, Pearson, Coe, & Gunnell, 2005; U.S. Department of Health and Human Services, 1999), even when experiencing levels of distress that are equivalent to females (Carpenter & Addis, 2000; Deane & Todd, 1996; Kessler, Brown, & Boman, 1981). Additionally, compared to non-Hispanic Whites, mental health treatment rates are remarkably low among Black and Asian men and immigrants (Neighbors et al., 2007; Wang, Lane, Olfson, Pincus, Wells, & Kessler, 2005). The finding that refugee men in our study did not differ significantly from refugee women with respect to anxiety, PTSD, and general symptoms lends important information regarding clinical assessment and treatment. Given that men are less likely to seek help, it is crucial that interventions are developed to recruit and retain at-risk male clients. The equal prevalence of men and women in our sample is a testament to extensive community outreach efforts that can serve to inform recruitment and retention of racial/ethnic minority men by mental health providers.

Findings related to torture status. These results highlight the need for effective and culturally sensitive interventions not only for torture survivors, but for refugees in general. In our sample, the distinction between torture survivors and refugees without a torture history is based upon the United Nation's definition of torture, which specifies

that the acts of pain and suffering inflicted must be done “by or at the instigation of or with the consent or acquiescence of” a government agent (IRCT, 2013). Based on this classification, two individuals with identical trauma profiles would have been designated differently in our study depending upon the characteristics of the perpetrator rather than the characteristics of the acts themselves. In reality, this distinction may be more artificial than meaningful. This finding stresses the need for the field of clinical psychology to move beyond a legal definition when assessing the psychological effects of torture. Indeed, a psychological definition that deemphasizes the perpetrator in order to emphasize intentionality and the acts themselves, may arguably exercise a more significant impact on psychological functioning. Future research could add clarity to this issue by investigating the role of perpetrator characteristics; number, type, and developmental timing of trauma/torture experiences; and time elapsed since the event(s) in order to establish whether such traits influence mental health outcomes.

Findings related to PTSD. Unexpectedly, on average, participants did not meet the clinical threshold for PTSD symptomatology or HTQ Total Score, despite the high level of reported trauma, and across 73% of our sample, torture. These results corroborate numerous other commentaries on the limitations of the Western diagnostic system in classifying trauma-related symptomatology in cross-cultural populations. The inclusion of negative trauma-related mood symptoms (e.g., shame, guilt) in the revised diagnostic criteria for PTSD in *DSM-5* (American Psychiatric Association, 2013) might better account for the experience of refugees and torture survivors, as persistent shame and guilt might be associated with persecution and torture. In fact, research has shown higher rates of guilt, shame, and low self-worth among ethnic/racial minorities experiencing racial

discrimination (Carter & Forsyth, 2010). However, as of yet, consistent measurement of these affective symptoms is not well established in the trauma literature. Studies are needed to validate the revised criteria, particularly in a highly traumatized cross-cultural sample.

Moreover, with a refugee population, it may be wise to consider traumatic stress symptoms and experiences outside those delineated by *DSM-5*. For example, the trauma experienced by refugees and torture survivors typically represents ongoing traumatic events, rather than “past” experiences. As such, new and expanded formulations, such as the chronic traumatic stress framework (Fondacaro & Mazzulla, 2015b), may be necessary to explain the psychological corollaries of exposure to trauma and torture among refugees. Fondacaro and Mazzulla (2015b) define CTS as “...not a disorder but rather the experience of persistent traumatic event(s), both past and continued that occur at any point across the lifespan, with sequelae that are perceived by the individual as impairing, regardless of symptom constellation or thresholds.” In this way, the CTS paradigm adopts a more inclusive, non-pathological viewpoint that recognizes the unique and understandable psychological responses of refugees to persistent traumatic experiences across time.

Findings related to multiple stigmas. Analyses testing a linear model of multiple stigmas produced non-significant results. The present research was barred from investigating a moderation model to explore interactions between race, sex, and religion due to demands for increased sample size to provide additional statistical power. As a first step, exploratory analyses sought to examine the impact of race among Muslims and religion among Asians. These results suggested between-group differences with respect

to religion. Moreover, overall, men and women differed with respect to depression. These results, in combination with the findings that Africans and Asians differed on posttraumatic stress symptoms, but no race differences were observed when analyses included only Muslims, formulate an evidentiary basis for more complex statistical modeling in the future. Increased sample size and statistical power would permit analyses testing interactions between the stigma variables (race, religion, sex) as well as group comparisons at the level of country of origin/ethnic group.

Chapter 6: Summary and Conclusion

The present study sought to explore the impact of stigma related to race, sex, and religion on the mental health of resettled refugees. In total, refugees exhibited high levels of psychopathology, with anxiety, depression, and general symptoms particularly elevated (meeting/exceeding clinical thresholds); PTSD and general posttraumatic stress symptoms were subthreshold, on average. Africans reported increased posttraumatic symptoms as compared to Asians when adjusting for sex and torture status. Across all racial groups, Muslims displayed clinical levels of anxious, depressive, and total symptoms. A significant between-group effect of religion on total symptoms among Asians was found. Analyses testing a linear model of the relation of multiple stigmas to psychological outcomes was non-significant. Results support the significance of race and religion in contributing to refugee mental health and call for culturally appropriate interventions to adequately treat refugees. Likewise, further investigation into the nature of the relation of stigma, and in particular, multiple stigmas, to psychological well-being is warranted.

Table 1

Descriptive Data for Demographic Study Variables

Characteristic	M	(SD)
Age		
Age in Years	43.69	13.06
Sex	n	%
Male	73	49.7
Female	73	49.7
Country of Origin	n	%
Bhutan/Nepal	58	39.5
Bosnia	17	11.6
Congo	7	4.8
Iraq	7	4.8
Myanmar/Burma	7	4.8
Somalia	33	22.4
Sudan	5	3.4
Other ^a	13	8.9
Race	n	%
Asian	65	44.2
Black or African	56	38.1
White or Caucasian	26	17.7
Immigration Status	n	%
Asylum-Seeker, Asylee, or Former Asylee	11	7.5
Permanent U.S. Resident	16	1.9
Refugee or Former Refugee	107	72.8
U.S. Citizen	11	7.5
Religion	n	%
Christianity	36	24.5
Hinduism	49	33.3
Islam	62	42.2

Note. $N = 147$

^aOther country of origin category includes participants from Angola, Burundi, Democratic Republic of Congo, Guinea, Iran, Moldova, Rwanda, and Zimbabwe

Table 1 Continued

Descriptive Data for Demographic Study Variables

Characteristic	n	%
Marital Status		
Single	21	14.3
Married	99	67.3
Separated or Divorced	11	7.4
Widowed	15	1.2
Highest Level of Education	n	%
No formal education	48	32.7
Some primary or secondary school, no degree	41	27.9
Finished secondary school	22	15.0
Some university, no degree	10	6.8
Bachelor's degree from university	10	6.8
Some graduate school, no degree	1	.7
Other	7	4.8
Live in a refugee camp prior to coming to U.S.	n	%
Yes	116	78.9
No	25	17.0
Torture Status	n	%
Yes	107	72.8
No	39	26.5

Note. $N = 147$

Table 2

Descriptive Data and Bivariate Correlations among Demographic and Outcome Variables

	Variables	M (SD)	2	3	4	5	6	7
1	Age	43.69 (13.06)	-.007	.05	-.04	-.001	-.03	-.06
2	Stigma Score	2.08 (.78)	---	.08	-.04	.01	.02	-.01
3	Anxiety Score	2.28 (.86)		---	.76**	.92**	.63**	.64**
4	Depression Score	2.25 (.76)			---	.96**	.64**	.66**
5	HSCL-25 Total Score	2.26 (.75)				---	.68**	.70**
6	PTSD Score	2.23 (.71)					---	.95**
7	HTQ Total Score	2.14 (.66)						---

Note. $N = 147$. Pooled statistics across 20 imputations are reported.

* $p < .05$. ** $p < .01$. *** $p < .001$

Table 3

Results of Analysis of Variance Comparing Africans to Asians by Sex and Torture Status on Psychological Outcomes

Outcome Variable	<i>F</i> (1, 118)	<i>p</i>	η^2
Anxiety Score			
Sex	1.14	.29	.01
Torture Status	.36	.57	.003
Depression Score			
Sex ^a	6.12	.02	.05
Torture Status	.08	.82	< .01
HSCL-25 Total Score			
Sex	3.91	.05	.03
Torture Status	.10	.81	.001
PTSD Score			
Sex	1.45	.24	.01
Torture Status	2.92	.10	.02
HTQ Total Score			
Sex	.99	.33	.01
Torture Status	1.05	.32	.01

Note. $N = 121$. Sex and torture status were entered as factors in all analyses. Pooled statistics across 20 imputations are reported.

^a Pairwise comparisons significant at $p < .05$ level

Table 4

Results of Analysis of Variance Comparing African Refugees to Asian Refugees by Race on Psychological Outcomes

Outcome Variable	<i>F</i> (1, 117)	<i>p</i>	η^2
Anxiety Score			
Sex	.76	.39	.01
Torture Status	.25	.65	< .01
Race	1.22	.28	.01
Depression Score			
Sex ^a	5.13	.03	.04
Torture Status	.11	.78	< .01
Race	1.12	.31	.01
HSCL-25 Total Score			
Sex	3.10	.08	.03
Torture Status	.06	.86	< .01
Race	1.31	.26	.01
PTSD Score			
Sex	.58	.47	< .01
Torture Status	2.22	.15	.02
Race ^a	7.79	.01	.06
HTQ Total Score			
Sex	.35	.57	< .01
Torture Status	.66	.44	.01
Race ^a	6.36	.01	.05

Note. $N = 121$. Race, sex, and torture status were entered as factors in all analyses. Pooled statistics across 20 imputations are reported.

^a Pairwise comparisons significant at $p < .05$ level.

Table 5

Estimated Marginal Means for Africans and Asians Across Psychological Outcomes

Outcome Variable	African		Asian	
	<i>EMM</i>	<i>SE</i>	<i>EMM</i>	<i>SE</i>
Anxiety Score	2.30	.16	2.12	.15
Depression Score	2.25	.14	2.11	.13
HSCCL-25 Total Score	2.27	.14	2.12	.12
PTSD Score ^a	2.27	.13	1.93	.12
HTQ Total Score ^a	2.22	.12	1.92	.11

Note. $N = 121$.

^a Significant difference ($p = .01$).

Table 6

Summary of Results of Linear Regression and Analysis of Variance Analyses Testing Effects of Stigma Score on Psychological Outcomes

Outcome Variable	ANOVA			Linear Regression			
	<i>F</i> (3, 143)	<i>p</i>	η^2	β	<i>S.E.</i>	<i>t</i>	<i>p</i>
Anxiety Score							
Stigma Score	.67	.58	.01	.08	.09	.92	.36
Depression Score							
Stigma Score	.34	.80	.01	-.04	.08	-.44	.66
HSCL-25 Total Score							
Stigma Score	.22	.88	< .01	.01	.08	.15	.88
PTSD Score							
Stigma Score	.44	.73	.01	.02	.08	.21	.83
HTQ Total Score							
Stigma Score	.34	.79	.01	-.01	.07	-.11	.91

Note. *N* = 147. Pooled statistics across 20 imputations are reported.

Table 7

Estimated Marginal Means for Levels of Stigma Score

Outcome Variable	Stigma Score = 0		Stigma Score = 1		Stigma Score = 2		Stigma Score = 3	
	<i>EMM</i>	<i>SE</i>	<i>EMM</i>	<i>SE</i>	<i>EMM</i>	<i>SE</i>	<i>EMM</i>	<i>SE</i>
Anxiety Score	1.8	.44	2.18	.17	2.34	.11	2.30	.13
Depression Score	2.09	.39	2.37	.15	2.23	.09	2.23	.11
HSCL-25 Total Score	1.98	.38	2.29	.15	2.27	.09	2.26	.11
PTSD Score	1.92	.37	2.21	.14	2.28	.09	2.20	.11
HTQ Total Score	1.93	.33	2.15	.13	2.19	.08	2.10	.10

Note. $N = 147$. Simple contrasts compared each level of stigma score to the reference category, Stigma Score = 0, which represented scores for White Christian Males. All simple contrasts were non-significant ($ps > .05$).

Table 8

Summary of Results of Linear Regression of Psychological Outcomes on Number of Stigmas (Zero versus One or More)

Outcome Variable	<i>F</i> (1, 145)	<i>p</i>	β	<i>SE</i>	<i>t</i>	<i>p</i>
Anxiety Score						
Stigma Score	1.31	.27	.09	.45	1.11	.27
Depression Score						
Stigma Score	.20	.68	.03	.39	.41	.68
HSCL-25 Total Score						
Stigma Score	.61	.45	.06	.39	.76	.45
PTSD Score						
Stigma Score	.85	.38	.07	.37	.88	.38
HTQ Total Score						
Stigma Score	.45	.51	.05	.34	.66	.51

Note. $N = 147$. Pooled statistics across 20 imputations are reported.

Table 9

Results of Analysis of Variance/Analysis of Covariance Comparing Muslims by Race on Psychological Outcomes

Outcome Variable	African		Asian		White/ Caucasian		F	df	p	η^2
	EMM	SE	EMM	SE	EMM	SE				
Anxiety Score ^a	2.52	.15	2.95	.37	2.38	.20	1.02	2, 55	.40	.04
Depression Score ^a	2.48	.16	3.08	.39	2.39	.21	1.34	2, 26	.31	.09
HSCL-25 Total Score ^a	2.42	.13	2.80	.31	2.51	.17	.76	2, 55	.49	.03
PTSD Score ^b	2.35	.18	2.30	.35	2.51	.21	.36	2, 56	.70	.01
HTQ Total Score ^b	2.31	.17	2.25	.32	2.36	.20	.31	2, 56	.74	.01

Note. $N = 59$. 3 participants were deleted listwise due to missing age data.

^a ANCOVA models included age as a covariate and race as a factor.

^b ANOVA models included race and immigration status as factors.

Table 10

Results of Analysis of Variance Comparing Asians by Religion on Psychological Outcomes

Outcome Variable	Christian		Hindu		Muslim		F	df	p	η^2
	EMM	SE	EMM	SE	EMM	SE				
Anxiety Score ^a	2.31	.26	2.08	.11	2.57	.33	1.45	2, 62	.28	.04
Depression Score ^b	2.54	.22	2.05	.18	2.44	.29	2.38	2, 60	.12	.07
HSCL-25 Total Score ^a	2.48	.21	2.00	.09	2.49	.25	3.65	2, 62	.03	.11
PTSD Score ^a	2.13	.20	1.96	.09	2.47	.25	2.63	2, 62	.10	.08
HTQ Total Score ^a	2.14	.19	1.88	.08	2.42	.22	3.54	2, 62	.04	.10

Note. $N = 65$.

^a Models included religion as a single factor. Groups did not differ by religion ($p > .05$).

^b Model included religion, sex, and torture status as factors. Groups did not differ by religion, sex, or torture status ($p > .05$).

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