An online program to reduce mental health stigma in refugee men.

Angela Nickerson, Yulisha Byrow, Rosanna Pajak, & Savannah Minihan

Refugee Trauma and Recovery Program

School of Psychology, UNSW
Refugee Trauma & Recovery Program,
School of Psychology, UNSW,
Sydney, NSW 2052 Australia

T: (02) 9385 0006
E: refugee@unsw.edu.au

www.rtrp-research.com

Suggested citation
AN OVERVIEW OF beyondblue’s STRIDE INITIATIVE

Following an open, competitive process, beyondblue with donations from the Movember Foundation, commissioned six action research partnerships to answer a key question:

“Can digital interventions, implemented at a local population level, promote change across the knowledge, attitudinal and/or behavioural components of stigma experienced and/or exhibited by men aged 30 to 64 years?”

The partnerships were all required to involve multiple perspectives – local community, academics, evaluators and designers – each contributing to an integrated innovative digital project.

The Stigma Reduction Interventions: Digital Environments (STRIDE) Initiative investigated the ‘real world’ effectiveness of evidence-informed interventions and prioritised research partnerships between the community and academics.

The six commissioned projects were:

- Better Out Than In, led by the AFL Players Association
- Contact+Connect, led by Incolink
- Out of the Blue: Pete & Dale, led by VAC
- Tell Your Story, led by UNSW Refugee Trauma & Recovery Program
- The Ripple Effect, led by National Centre for Farmer Health
- Y Fronts, led by CGA Consulting

beyondblue received results of the six projects in mid-2017. These results provided us with insights into how to best use digital channels to promote behaviour change in men in their middle years so they report less stigma around mental health and/or suicide.

More information on the STRIDE Initiative, including detailed results of the research, is available at: beyondblue.org.au/stigma.

The STRIDE Initiative is a beyondblue project funded with donations from the Movember Foundation.
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>7</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>8</td>
</tr>
<tr>
<td>Research Background</td>
<td>8</td>
</tr>
<tr>
<td>Project Overview &amp; Objectives</td>
<td>8</td>
</tr>
<tr>
<td>Mental Health Stigma in Refugee Men</td>
<td>9</td>
</tr>
<tr>
<td>Development of the Tell Your Story Intervention</td>
<td>10</td>
</tr>
<tr>
<td>Evaluation of the Tell Your Story Intervention</td>
<td>10</td>
</tr>
<tr>
<td>Conclusions &amp; Recommendations</td>
<td>11</td>
</tr>
<tr>
<td>Introduction</td>
<td>13</td>
</tr>
<tr>
<td>Refugees and Posttraumatic Stress Disorder</td>
<td>13</td>
</tr>
<tr>
<td>Mental Health Stigma</td>
<td>14</td>
</tr>
<tr>
<td>Mental Health Stigma in Refugee Communities</td>
<td>14</td>
</tr>
<tr>
<td>How can Self-Stigma be Reduced?</td>
<td>15</td>
</tr>
<tr>
<td>Project Overview</td>
<td>17</td>
</tr>
<tr>
<td>Project Governance</td>
<td>18</td>
</tr>
<tr>
<td>Phase 1: Understanding Mental Health Stigma in Refugee Men</td>
<td>20</td>
</tr>
<tr>
<td>Background</td>
<td>20</td>
</tr>
<tr>
<td>Objectives</td>
<td>20</td>
</tr>
<tr>
<td>Qualitative Investigation of Self-Stigma and Help-Seeking</td>
<td>20</td>
</tr>
<tr>
<td>Methodology</td>
<td>20</td>
</tr>
<tr>
<td>Analysis</td>
<td>21</td>
</tr>
<tr>
<td>Findings</td>
<td>21</td>
</tr>
<tr>
<td>The Nature of the Refugee Experience</td>
<td>21</td>
</tr>
<tr>
<td>Culture and Mental Health</td>
<td>23</td>
</tr>
<tr>
<td>Talking About Symptoms is Not Useful</td>
<td>23</td>
</tr>
<tr>
<td>Fear of Negative Responses From Community</td>
<td>23</td>
</tr>
<tr>
<td>Quantitative Investigation of Self-Stigma and Help-Seeking</td>
<td>25</td>
</tr>
<tr>
<td>Methodology</td>
<td>25</td>
</tr>
<tr>
<td>Analysis</td>
<td>25</td>
</tr>
<tr>
<td>Findings</td>
<td>26</td>
</tr>
<tr>
<td>Phase 2: Developing the Tell Your Story Intervention</td>
<td>30</td>
</tr>
<tr>
<td>Background</td>
<td>30</td>
</tr>
<tr>
<td>Development of the Intervention</td>
<td>30</td>
</tr>
<tr>
<td>Intervention Content</td>
<td>30</td>
</tr>
<tr>
<td>Intervention Design and Technology</td>
<td>31</td>
</tr>
<tr>
<td>Languages and Translation</td>
<td>31</td>
</tr>
<tr>
<td>Videos</td>
<td>32</td>
</tr>
<tr>
<td>Objectives</td>
<td>32</td>
</tr>
</tbody>
</table>
Methodology............................................................................................................. 32
Findings....................................................................................................................... 32
Module Content for the Tell Your Story Program.................................................... 34
Evaluating the Tell Your Story Intervention............................................................. 40
Background.................................................................................................................. 40
Objectives..................................................................................................................... 40
Methodology................................................................................................................ 40
   Recruitment.............................................................................................................. 40
   Screening.................................................................................................................. 41
   Study Design........................................................................................................... 42
   Assessment.............................................................................................................. 42
   Participants.............................................................................................................. 44
   Reasons for Ineligibility.......................................................................................... 44
   Barriers to Completing Baseline Assessment....................................................... 45
   Analysis.................................................................................................................... 45
Findings......................................................................................................................... 46
   Demographics......................................................................................................... 46
   Past Experiences—Trauma Exposure.................................................................... 46
   Current Experiences—Post-Migration Living Difficulties..................................... 47
Tell Your Story In-Program Findings....................................................................... 47
Tell Your Story Intervention Findings....................................................................... 51
   Self-Stigma Related to PTSD.............................................................................. 51
   Self-Stigma for Help-Seeking.............................................................................. 54
   Help-Seeking Intentions....................................................................................... 55
   Help-Seeking Behaviour....................................................................................... 56
Secondary Outcomes................................................................................................. 58
   Quality of Life....................................................................................................... 58
   Symptoms of PTSD............................................................................................... 59
Tell Your Story Program User Experience................................................................ 60
   Access.................................................................................................................... 60
   Ease of Use............................................................................................................. 60
   Preferred Components of the Tell Your Story Program.................................... 60
   Usefulness and Relevance of Information Presented in Program...................... 61
   Videos..................................................................................................................... 61
   Participant Engagement....................................................................................... 62
Key Insights from the Tell Your Story Project......................................................... 63
   Understanding Self-Stigma in Refugee Men....................................................... 63
   Reducing Self-Stigma in Refugee Men................................................................. 64
Recommendations....................................................................................................... 65
   Interventions Targeting Self-Stigma in Refugee Men.......................................... 65
   Project Learnings................................................................................................. 65
ACKNOWLEDGEMENTS

This research was funded by beyondblue with donations from the Movember Foundation and conducted by the Refugee Trauma and Recovery Program at the School of Psychology, UNSW in partnership with Settlement Services International and The Black Dog Institute at UNSW.

Many individuals and organisations have contributed to this project. First, we would like to thank beyondblue and the Movember Foundation for recognising the need for an intervention of this type, and funding this research. In particular, we would like to thank Andrew Thorp for his valuable guidance and support throughout the project. We are deeply thankful to the members of both the Tell Your Story Steering Committee and Community Advisory Boards for their useful insights into the nature of self-stigma in refugee communities and feedback throughout the various stages of development of the Tell Your Story program.

We would also like to thank the following people for their valuable contribution to the project: Jacinto Santamaria, Cesar Anonuevo, Helen Christensen and Nicole Cockayne from the Black Dog Institute at UNSW, Rachael Thornton from Thornyvision, Corrin Grant, Tadgh McMahon from Settlement Services International, Lillian Le, Amber Hamilton and Belinda Liddell from the Refugee Trauma and Recovery Program (RTRP) at UNSW, Tobias Spiller from Zurich University, Richard Bryant, Anneliese Todarello and Sarah Fernandes from UNSW, Matt Delprado from the Loom, and Gheed Aldamook.

We would also like to thank the many groups and organisations who have helped us to develop and/or promote the intervention. First and foremost, we would like to thank Amitabh Rajouria from SSI for his invaluable assistance in promoting Tell Your Story. We would also like to thank the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), the Australian Red Cross, House of Welcome, Asylum Seeker Centre, NAVITAS, NSW Transcultural Mental Health Centre, Core Community Services, The Salvation Army, Liverpool Migrant Resource Centre, NSW Refugee Health Service, the Australian Iranian Community Organisation, Refugee Council of Australia, Jesuit Refugee Service, Canterbury-Bankstown City Council, Lentara, and the Asylum Seekers Resource Centre.

We are very grateful to the refugee men who agreed to share their stories in the videos featured in the intervention. Their generosity and willingness to help others was immensely appreciated. Finally, and most importantly, we would like to thank the individuals who took part in this project. By generously sharing their experiences, and providing us with feedback on the Tell Your Story intervention, they have reinforced the importance of overcoming self-stigma, and highlighted the strength and resilience that is inherent in refugee communities.
EXECUTIVE SUMMARY

Research Background

The number of displaced persons worldwide is over 65 million and growing. Australia resettles approximately 14,000 refugees fleeing persecution every year. Refugees are typically exposed to multiple traumatic events in their home countries and during displacement. Refugees report rates of posttraumatic stress disorder (PTSD) that are over five times that of the broader Australian community. This disorder is associated with other psychological disorders such as depression, as well as suicidality and physical health problems. Despite these high rates of psychological distress, refugees exhibit low levels of help-seeking behaviour and mental health service utilisation.

Mental health stigma is a powerful barrier to help-seeking in refugees, particularly amongst men. The research literature has identified key factors that are associated with low help-seeking amongst refugees, including:

- Cultural beliefs about mental health
- Masculinity norms
- The nature of traumatic experiences
- Displacement from usual sources of social and psychological support

Despite high rates of PTSD and low levels of help-seeking amongst refugee men, to date there exists no specific intervention to reduce mental health stigma in refugee men.

Project Overview & Objectives

In recognition of the need to reduce mental health stigma and increase help-seeking in refugee men, beyondblue, with donations from the Movember Foundation, commissioned the Tell Your Story (TYS) project, as part of the STRIDE initiative. This project was conducted by the Refugee Trauma and Recovery Program at the School of Psychology UNSW, in partnership with Settlement Services International and the Black Dog Institute at UNSW.

The objectives of the Tell Your Story project were to:

1) Increase knowledge regarding mental health stigma in refugee men from Arabic, Farsi and Tamil-speaking backgrounds.

2) Develop and evaluate an online intervention designed to reduce self-stigma and increase help-seeking in refugee men from Arabic, Farsi and Tamil-Speaking backgrounds.
This project encompassed three phases and implemented multiple research methods to address the project objectives.

- **Phase One** investigated mental health stigma in refugee men using qualitative interviews and a quantitative survey.
- **Phase Two** encompassed the development and pilot-testing of the TYS intervention.
- **Phase Three** was a randomised controlled trial evaluating the efficacy of the TYS intervention.

At each stage of the project, the research was informed by a Steering Committee and Community Advisory Boards comprising refugee community leaders and representatives, refugee support service providers and academic experts in refugee mental health.

**Mental Health Stigma in Refugee Men**

Eleven refugee community representatives and service providers participated in qualitative interviews about mental health stigma. 102 refugee men from Arabic, Farsi and Tamil-speaking backgrounds completed an online survey investigating mental health stigma. In addition, participants taking part in the intervention provided information about their help-seeking concerns. The key findings were as follows:

- Self-stigma related to mental health was identified as an important barrier to help-seeking for psychological symptoms in refugee men. Self-stigma related to PTSD symptoms was more prevalent than self-stigma related to help-seeking.
- Refugee men reported high levels of negative beliefs regarding their capacity to manage psychological distress. Many were also concerned about the negative social consequences of others finding out about their PTSD symptoms.
- Refugee men were generally positive about the prospect of seeking help and recognised the benefits that might come from talking to formal and informal help-seeking sources. Men who took part in the intervention also indicated that talking about their mental health difficulties could be helpful to them and others. However, few had engaged in help-seeking in the two weeks prior to participating in the study.
- Key barriers to seeking help included difficulty trusting others, believing that talking about psychological difficulties is not useful or may even be harmful, and fear of negative evaluation from their community. These factors were exacerbated by guilt and shame arising from the refugee experience and cultural conceptions of masculinity and mental health. Men taking part in the program also indicated that they were concerned about burdening others, and that they didn’t know where to access assistance for mental health difficulties.
Development of the Tell Your Story Intervention

The TYS intervention was developed as a 12-session online intervention that aimed to reduce mental health stigma and increase help-seeking in refugee men. While developing this intervention, we drew on evidence-based principles of mental health stigma reduction including psychoeducation, social-contact and reappraisal, as well as culturally-specific information gathered in Phase One of the project. This program was created in Arabic, Farsi and Tamil, with extensive language and cultural consultation with the Community Advisory Boards established for this project. The intervention featured:

- Videos of two refugee men from each language group talking (in their own language) about how they had overcome mental health stigma. These men also spoke about their positive help-seeking experiences.
- Psychoeducation to normalise the experience of PTSD symptoms and provide information about possible sources of informal and formal support.
- Interactive activities to consolidate learning and develop concrete help-seeking plans.

Evaluation of the Tell Your Story Intervention

A randomised controlled trial was conducted to rigorously evaluate the efficacy of the TYS intervention in reducing mental health stigma and increasing help-seeking. Participants were randomly assigned to complete the TYS intervention or to a wait-list control group. Participants were assessed at baseline, post-treatment and one-month follow-up via online surveys. At the time of this report, 63 individuals had completed all three time-points. The key outcomes were as follows:

- Participants who took part in TYS showed greater reductions in shame, help-seeking inhibition and feelings of social inadequacy, compared to those in the wait-list control group.
- Participants who took part in the TYS intervention showed greater improvement in physical health-related quality of life compared to the wait-list control group.
- Participants who took part in TYS showed greater increases in the number of informal help-seeking sources they accessed compared to those in the wait-list control group.
- Participants in the wait-list control group showed increases in formal help-seeking intentions from post-treatment to follow-up. This difference was not observed in participants who completed TYS.
- For participants who took part in TYS, the number of help-seeking sources accessed throughout the intervention increased with the number of modules completed.
Participants who took part in TYS found the program to be easy to use, and the information useful and relevant to them. The majority of participants used the program on a smartphone. Engagement in the program was strongest in the early modules, and one-fifth of participants completed the entire program.

Participants found the information components of the intervention to be especially useful, which is consistent with the finding that many participants did not know where to seek help.

Conclusions & Recommendations

TYS was effective in reducing self-stigma in refugee men from Arabic, Farsi and Tamil-speaking backgrounds. There is some evidence that TYS was also effective in increasing help-seeking, however the assessment timeframe of the project may not have been adequate to detect change in help-seeking behaviour. It would be beneficial to evaluate TYS with a longer follow-up assessment period to determine whether the program results in long-term changes in stigma and help-seeking.

Mental health stigma is a prevalent and salient concern in male refugees from Arabic, Farsi and Tamil-speaking backgrounds. This represents a significant barrier to accessing mental health care amongst refugee men with PTSD symptoms. Further research should be conducted to better understand mental health stigma in refugees from a variety of backgrounds.

The unique circumstances of refugee communities, including exposure to interpersonal trauma and displacement from important sources of support, as well as specific cultural beliefs around mental health and masculinity, contribute to self-stigma in refugees. Interventions targeting self-stigma in these communities should be specifically tailored to the experience and cultural background of refugee groups.

Retention rates in the TYS program were high. Participants who completed more modules were more likely to engage in help-seeking following the intervention. Completion of multiple modules may have been reduced by the time-locking of modules required for the randomised controlled trial design. There is a need to evaluate TYS in an uncontrolled trial to determine whether it is effective in reducing stigma as a freely-available program without time constraints.

Services in the refugee sector were overwhelmingly positive regarding the TYS intervention, indicating that the program addressed an important unmet need in the area. Feedback indicated that services would welcome the continuation of the TYS program as a resource to reduce stigma in their clients. It was also requested that the program be adapted for women, other age groups, and other language groups.
Refugee services have identified a gap in resources that their staff can use to work with and address mental health stigma in their clients. The development, dissemination and evaluation of evidence-based stigma reduction resources amongst refugee services would be beneficial to support the work of refugee support services.

While refugee men report high levels of stigma related to PTSD symptoms, many indicated that they were willing to seek help for these difficulties. Despite this, help-seeking amongst participants was low. Findings from this study suggest that there are a number of salient barriers to seeking help, including prioritising practical needs and fear of negative social evaluation. It would be beneficial to integrate stigma reduction programs like TYS into refugee services that address practical needs. The implementation of a stepped-care approach whereby recently-arrived refugees are directed to TYS after having met their settlement needs may increase uptake of the intervention.

Other key barriers to participation in the TYS program included lack of computer literacy and lack of access to a computer. Providing plain language, printed resources on stigma reduction would be beneficial.
REFUGEES AND POSTTRAUMATIC STRESS DISORDER

There are an increasing number of people displaced by conflict and persecution worldwide. In 2016, the United Nations estimated that 65.3 million people were forcibly displaced globally (UNHCR, 2016). By definition, refugees experience persecution in their home countries. This means that they are typically exposed to multiple instances of traumatic events such as physical assault, witnessing the murder of loved ones, and torture (Steel, et al., 2009). Accordingly, a substantial percentage of refugees meet criteria for posttraumatic stress disorder (PTSD, 30.6%; Steel et al., 2009). These rates are much higher than those observed in the wider population and suggest that refugees represent a subset of the community that are particularly vulnerable to developing mental health problems.

PTSD is a psychological disorder that may occur as a result of witnessing or experiencing a traumatic event. The core symptoms of PTSD include:

1. **Re-experiencing symptoms**—Feeling as though you are reliving the traumatic event through nightmares and intrusive memories.

2. **Avoidance symptoms**—Avoiding situations, people or places that remind you of the traumatic event.

3. **Negative beliefs and emotions**—Negative changes in how you feel and see the world since the traumatic experience.

4. **Hyperarousal symptoms**—Persistently feeling alert and being “on the look out” for danger.

PTSD in refugees has been associated with numerous negative outcomes including comorbid psychological disorders, suicidality, increased physical health problems and impaired psychosocial functioning (Bhui et al., 2006; Hermansson, Timpka, & Thyberg, 2002; Jankovic et al., 2013; Lie, 2002; Mollica, et al., 2001). Although
many refugees experience symptoms of PTSD, research suggests that help-seeking for psychological care is low in refugee communities, especially amongst men (Lamkaddem et al., 2014; Minas & Silove, 2009; Piwowarczyk, Bishop, Yusuf, Mudumba, & Raj, 2014). One reason that refugees may be reluctant to seek help for psychological difficulties relates to mental health stigma.

**Mental Health Stigma**

Stigma is a multifaceted phenomenon. For example, public stigma refers to negative perceptions adopted by the wider community toward other individuals who do not conform to some conventional ideal. Self-stigma refers to the internalisation of public stigma, whereby public negative attitudes and beliefs are directed towards oneself. This may have a harmful effect on self-esteem and self-efficacy (Corrigan, Kerr, & Knudsen, 2005). Mental health stigma can be conceptualised as negative beliefs about both mental health and accessing mental health services.

Mental health stigma has been demonstrated to have a negative impact on psychosocial outcomes such as hope, self-efficacy, social support and integration as well as symptom severity and treatment adherence (Livingston & Boyd, 2010). In addition, mental health stigma has been associated with a range of negative consequences, including unemployment and income loss, interpersonal difficulties, decreased self-esteem, and low treatment-seeking behaviour (Adewuya, Owoeye, Erinfolami, & Ola, 2011; Clement et al., 2015; Corrigan, Watson, & Barr, 2006; Link, 1982).

**Mental Health Stigma in Refugee Communities**

**Figure 1. Factors contributing to mental health stigma in refugee communities**

There are a number of factors that influence perceptions of psychological symptoms and help-seeking in refugee groups. Specific negative cultural beliefs regarding mental health, masculinity norms, the nature of the traumatic experience and displacement from important sources of support mean that refugee men with PTSD may be highly vulnerable to the effects of self-stigma (see Figure 1).
Cultural beliefs. Societal knowledge of and attitudes towards mental health are strongly influenced by cultural values and norms. Mental health stigma is thus likely to present differently according to the specific cultural background of the individual. For example, beliefs that psychological symptoms are indicative of severe mental illness may contribute to mental health stigma.

Masculinity norms. Norms regarding masculinity vary depending on the cultural context in which they occur. Many cultures, however, associate masculinity with characteristics such as stoicism, strength and restriction of emotional expression (Levant, Wimer, Williams, Smalley, & Noronha., 2009; Vogel, Heimerdinger-Edwards, Hemmer, Hubbard., 2011). Research indicates that conforming to these traditional masculine norms predicts negative attitudes towards help-seeking (Levant et al., 2009).

Displacement from support. Many refugees are separated from family and friends who remain in their country of origin. Lack of social support in the resettlement country has been linked to negative psychological outcomes (Li, Liddell & Nickerson, 2017). Separation from family and friends, combined with lack of familiarity with local services may represent a significant barrier to help-seeking in refugee communities.

How Can Self-Stigma Be Reduced?

Recent reviews point to a number of strategies that may be effective in targeting mental health self-stigma. Mittal, Sullivan, Chekuri, Allee, and Corrigan (2012) propose that interventions can (1) directly alter an individual’s stigmatising beliefs and attitudes about mental illness and/or (2) improve stigma-related coping skills by strengthening self-esteem, empowerment, and help-seeking behaviour. Specific strategies that have been found to be useful in reducing self-stigma include:

Education: Education involves challenging stereotypes regarding mental illness by providing accurate information (beyondblue, 2012). A review of community-based interventions indicates that psychoeducation is a common and effective strategy for reducing stigma related to mental health (Reavley & Jorm, 2013; Yanos, Luckstend, Drapalski, Rowe, Lysaker, 2015).

Reappraisal: Cognitive reappraisal is a well-supported emotion regulation strategy that forms the basis of many evidence-based interventions for psychological disorders (Gross & John, 2003), including PTSD (Ehlers & Clark, 2000). Furthermore, there is emerging evidence that cognitive reappraisal is an efficacious strategy for reducing self-stigma in traumatised samples (Dicksten, Vogt, Handa, & Litz, 2010; Mittal, et al., 2012). Accordingly, data from research
conducted at the UNSW Refugee Trauma and Recovery Program indicates that cognitive reappraisal can reduce trauma-related distress in refugees with PTSD (Nickerson et al., 2017).

Social-contact: Social-contact involves “planned interactions between people with mental illness and key groups”. It represents a fundamental component of stigma reduction interventions (Corrigan, 2011) and is widely recognised as an effective strategy in reducing stigma.

When designing a self-stigma intervention for refugee men, it is critical to adapt evidence-based stigma reduction strategies according to cultural context and refugee-specific factors.
PROJECT OVERVIEW

This project was conducted with the **overall goals** of (1) increasing knowledge of self-stigma related to mental health and help-seeking in refugee men, and (2) developing and evaluating an intervention to reduce self-stigma and increase help-seeking in refugee men.

This project focused on men from **Arabic, Farsi and Tamil-speaking backgrounds**, as these represent the largest groups of refugees resettled in New South Wales in recent years.

This project comprised three phases.

### Phase 1. Understanding Mental Health Stigma in Refugee Men
- Qualitative interviews were conducted with Community Advisory Board members to elicit information regarding mental health and help-seeking stigma in these refugee communities.
- Quantitative data was elicited on self-stigma related to PTSD and help-seeking, and actual and intended help-seeking behaviour in refugee men.

### Phase 2. Developing the TYS Intervention
- Content for the online intervention was developed using findings from the qualitative interviews in Phase 1, and evidence from the stigma reduction literature.
- Videos were filmed with refugee men from Arabic, Farsi and Tamil-speaking backgrounds.
- The web-based intervention was developed, translated and programmed.
- Pilot-testing of the intervention as conducted by members of the Community Advisory Boards to elicit feedback and iteratively improve the program.

### Phase 3. Evaluating the TYS Intervention
- A randomised controlled trial was conducted to rigorously evaluate the efficacy of the TYS intervention. Participants were randomly assigned to either receive the intervention or be allocated to a wait-list control group. Self-stigma and help-seeking were indexed at baseline, post-intervention and follow-up time-points for both the intervention and wait-list control groups.
PROJECT GOVERNANCE

An outline of the project governance structure is presented in Figure 2 below.

The Refugee Trauma and Recovery Program at the School of Psychology, UNSW, was responsible for conducting the research described in this report, including literature reviews, study design, developing qualitative interview schedules and quantitative surveys, design of the intervention, promotion of the study, screening of potential participants with the use of telephone interpreters, following-up participants, and data analysis and report preparation.

Figure 2. Project governance
The project **Steering Committee** comprised experts in the field of refugee mental health and service provision, as well as refugee community leaders. This Committee reviewed the study design and procedures, and provided feedback on the intervention via phone and email.

The **Community Advisory Boards** provided valuable information on culturally-specific aspects of mental health and stigma, and pilot-tested the intervention, as well as provided feedback on the study design and procedures. Initially, we identified individuals who held community or cultural expertise, including those who could speak about the target community, those who could speak on behalf of their community and those who could share their own experiences. Within the Farsi, Arabic and Tamil-speaking communities, we found many of our community advisors spoke from multiple perspectives. For example, many were refugee men who had taken on roles as community leaders or worked professionally with refugee communities. Following initial Community Advisory Board meetings with each language group, Community Advisory Board members were contacted individually by phone.

The involvement of our study partners Settlement Services International and the Black Dog Institute at UNSW was also vital to the success of this study.

**Settlement Services International (SSI)** represents the largest refugee settlement services provider in New South Wales. The input of SSI ensured that the program directly addressed the needs of the target communities. SSI also played a large role in study recruitment by promoting the intervention to their clients.

The **Black Dog Institute** was our digital partner on this project, and were responsible for developing and programming the intervention and assessment surveys, and providing technical support. Their expertise in developing evidence-based interventions targeting factors related to mental health ensured that the TYS intervention was dynamic, engaging and functional. In this project, we were able to use an existing web-based platform developed by the Black Dog Institute. This enabled us to design, implement and program the intervention (in three languages) in a relatively short time-frame.
PHASE 1:
UNDERSTANDING MENTAL HEALTH STIGMA
IN REFUGEE MEN

Background

Despite evidence that mental health stigma represents an important barrier to accessing treatment for psychological disorders, there has been relatively little research conducted specifically examining self-stigma in refugee men. Phase 1 of this project proposed to investigate how self-stigma related to PTSD and help-seeking manifested in refugee men resettled in Australia.

Phase 1 of the project encompassed two parts. The first part comprised qualitative interviews with members of the Community Advisory Board to elicit information regarding their perceptions of self-stigma related to PTSD and help-seeking in their community. The second part involved the administration of standardised questionnaires on self-stigma and help-seeking to participants as part of baseline data collection for the evaluation of the TYS intervention.

Qualitative Investigation of Self-Stigma and Help-Seeking

Objectives

1. To explore mental health stigma in refugee communities.
2. To investigate stigma related to help-seeking in refugee communities.
3. To examine barriers to help-seeking in refugee communities.
4. To identify possible sources of informal and formal support for refugees experiencing psychological distress.

Qualitative interviews were conducted with members of the Community Advisory Board to elicit perceptions of self-stigma relating to mental health and help-seeking in Arabic, Farsi and Tamil-speaking refugee communities.

METHODOLOGY

Participants were 11 adult male refugee community leaders, as well as caseworkers and counsellors working with refugees. Of these, three were from Arabic-speaking backgrounds, four from Farsi-speaking backgrounds, and three from Tamil-speaking backgrounds.
After providing informed consent, participants engaged in either a face-to-face or telephone interview lasting approximately 45 minutes. These interviews comprised open-ended questions, which aimed to explore culturally-specific taxonomies related to mental health stigma and help-seeking.

ANALYSIS

The interview data was examined by thematic analysis. This methodology is used to identify broad themes across the data without imposing any pre-existing theoretical framework. NVivo software was used to conduct line-by-line coding of the interview transcripts and codes were grouped into potential themes and subthemes.

FINDINGS

The thematic analysis led to the identification of four key themes, each reported as being a critical factor contributing to mental health and help-seeking stigma. These themes arose in interviews with individuals across cultural groups.

THE NATURE OF THE REFUGEE EXPERIENCE

Participants reported that specific aspects of the refugee experience were linked to both psychological distress and reduced help-seeking. In particular, exposure to multiple traumatic events prior to resettlement was associated with both psychological symptoms and reluctance to access support services. Participants stated that, for many refugees, traumatic events experienced in the context of persecution had been interpersonal in nature. For example, many refugees had witnessed other people being seriously injured or killed or had been physically assaulted themselves. The experience of repeated interpersonal trauma reportedly led to reduced overall trust in others. In addition, these traumatic events were often inflicted by authority figures, potentially leading to mistrust of government departments and services. Accordingly, fear and mistrust arising from past experiences was identified as an important factor contributing to reluctance to discuss mental health difficulties.

In addition, the nature of these traumatic experiences was reported to lead to emotional responses that contribute to reluctance to disclose mental health difficulties, especially for men. Men are more likely to be exposed to traumatic events such as torture, beatings, incarceration and witnessing the murder of loved ones in their home countries. Experiences such as these were reportedly often used as tools to repress dissent in refugees’ home countries, and are thus designed to cause maximum psychological distress. For example, individuals experiencing torture may have been forced to participate in degrading acts, leading to feelings of shame. Individuals who have witnessed the murder of loved ones or strangers may have felt guilty about being unable to prevent this action. Accordingly, these experiences were suggested to have been especially likely to induce feelings of guilt and shame, as well as reduced self-worth. These responses were also reported to exacerbate
self-stigma experienced by refugee men in relation to their symptoms.

Feelings of shame and guilt were also reported to arise in the settlement environment. Settlement in a host country poses enormous challenges, which may include difficulties finding employment or education, and lack of access to financial resources. These challenges are often made more difficult by debilitating psychological symptoms. It was reported that, if an individual felt that he was unable to effectively care for his family, this may lead to further feelings of shame and guilt. This is likely to be associated with heightened self-stigma related to PTSD symptoms and help-seeking.
While it is important to note that there is substantial variation in beliefs about mental health both between and within cultural groups, key common themes arose from interviews with individuals from various backgrounds. In particular, participants highlighted that mental health difficulties are sometimes perceived negatively within their communities, with individuals with even mild psychological symptoms being labelled as “crazy”. Accordingly, it was reported that community members may perceive individuals with mental health difficulties as being unable to function effectively in their daily lives, or recover from psychological problems.

Participants linked these negative beliefs to minimal availability of mental health services and support in their countries of origin. Given these services may not be widely available, individuals requiring psychological assistance were perceived as having very severe mental health difficulties. In addition, participants reported that, in these contexts, individuals with mental health problems tend to experience high rates of homelessness and involuntary hospitalisation. Participants stated that this contributed to the perception that individuals with mental health difficulties were unable to function in society and were in need of intensive intervention.

Participants reported that many refugees are highly focused on their immediate practical needs in relation to settling effectively in their host community. Accordingly, practical assistance may be perceived as being more useful than psychological support, especially for those who have recently resettled in Australia.

In addition, participants reported that some community members believe that talking about emotional or mental health difficulties will lead to increased distress. This is particularly likely to be the case in the context of PTSD, where talking about symptoms will remind the individual of the traumatic events he or she has experienced, potentially leading to an increase in symptoms such as nightmares. It was reported that many individuals prefer to not to talk about their symptoms to avoid reliving painful experiences, and for fear that distress associated with being reminded of the trauma will prevent them from being able to function effectively in their everyday lives.

One of the most salient barriers to help-seeking reported by participants was fear of negative responses from other members of the community. Participants reported that many refugees may be reluctant to engage in both formal and informal help-seeking for fear that this information would be passed on to other community members. This could then lead to the individual being negatively evaluated due to perceptions of mental health outlined previously.

In particular, participants identified a fear amongst community members that they would lose
the respect of their community if they disclose mental health difficulties. Several participants also stated that many refugees are concerned about negative judgment extending to the individual's family members, and that the individual would be highly motivated to avoid bringing shame to his family. Ultimately, some individuals fear that this may lead to ostracism or rejection from the community.

“What can a counsellor do? He's not going to give me a protection visa, or she's not going to give me my visa, or she's not (going to) send my application to the department, so there is no point talking about it”.

“Mad, means a person... No one is taking them inside their house. They will be talking alone... You do not have your own identity. Nowhere to show who you are... Those sorts of people do not have a proper life. They cannot live in a house, they cannot have food (...) they do not have a lifestyle... And they would be living in the streets, dying in the streets”.

“It's so scary and that's when the avoidance comes to it. 'I don't want to talk about it, I don't want to say anything to anyone about it, I just want to forget about it and run away'”.

“And the way people look at others with mental health conditions (...) they are not accepted, they are rejecting those people... And they do believe that anyone been seen by a psychologist, anyone be seen by a counsellor, that person be considered as a crazy person”.

Quantitative Investigation of Self-Stigma and Help-Seeking

A quantitative study of self-stigma related to PTSD and help-seeking, as well as help-seeking behaviours and intentions was conducted with refugees from Arabic, Farsi and Tamil-speaking backgrounds.

METHODOLOGY

Measures were administered as part of the baseline assessment of individuals who took part in the randomised controlled trial. Participants completed these measures online prior to commencing the intervention or wait-list period.

Participants were 102 refugees (79 from Arabic-speaking, 17 from Farsi-speaking and 6 from Tamil-speaking backgrounds).

All measures were translated into the relevant languages (Arabic, Farsi and Tamil) and blind back-translated, with discrepancies rectified jointly by translators experienced in working with mental health material and the research team (see Table 1).

Table 1. Constructs measured and scales used

<table>
<thead>
<tr>
<th>Construct</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-stigma related to PTSD</td>
<td>Self-Stigma for Depression Scale (adapted to PTSD; Barney et al., 2010)</td>
</tr>
<tr>
<td>Help-seeking intentions</td>
<td>General Help-Seeking Questionnaire (Deane, Wilson, &amp; Ciarrochi, 2001)</td>
</tr>
<tr>
<td>Help-Seeking behaviours</td>
<td>Actual Help-Seeking Questionnaire (Rickwood et al., 2005)</td>
</tr>
</tbody>
</table>

ANALYSIS

Frequencies of item endorsement were derived using SPSS v 24.
FINDINGS

Figure 3. Self-stigma related to Posttraumatic Stress Disorder

<table>
<thead>
<tr>
<th>Belief</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should be stronger</td>
<td>32.4</td>
<td>53.9</td>
<td>8.8</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>Should be able to ‘pull myself together’</td>
<td>22.5</td>
<td>62.7</td>
<td>11.8</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Should be able to cope with things</td>
<td>22.5</td>
<td>49</td>
<td>20.6</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td>Disappointed in myself</td>
<td>18.6</td>
<td>25.5</td>
<td>23.5</td>
<td>22.5</td>
<td>8.8</td>
</tr>
<tr>
<td>Only had myself to blame</td>
<td>14.7</td>
<td>25.5</td>
<td>31.4</td>
<td>17.6</td>
<td>9.8</td>
</tr>
<tr>
<td>Wouldn’t want people to know I wasn’t coping</td>
<td>12.7</td>
<td>25.5</td>
<td>28.4</td>
<td>27.5</td>
<td>5.9</td>
</tr>
<tr>
<td>Ashamed</td>
<td>11.8</td>
<td>29.4</td>
<td>31.4</td>
<td>21.6</td>
<td>4.9</td>
</tr>
<tr>
<td>A burden to others</td>
<td>10.8</td>
<td>23.5</td>
<td>23.5</td>
<td>31.4</td>
<td>10.8</td>
</tr>
<tr>
<td>Couldn’t contribute much socially</td>
<td>10.8</td>
<td>26.5</td>
<td>28.4</td>
<td>26.5</td>
<td>7.8</td>
</tr>
<tr>
<td>Inferior to other people</td>
<td>9.8</td>
<td>22.5</td>
<td>23.5</td>
<td>32.4</td>
<td>20.6</td>
</tr>
<tr>
<td>Embarrassed</td>
<td>9.8</td>
<td>30.4</td>
<td>32.4</td>
<td>20.6</td>
<td>5.9</td>
</tr>
<tr>
<td>Embarrassed about seeking help for PTSD</td>
<td>8.8</td>
<td>22.5</td>
<td>33.3</td>
<td>23.5</td>
<td>11.8</td>
</tr>
<tr>
<td>Weak if I take medication for PTSD</td>
<td>7.8</td>
<td>21.6</td>
<td>25.5</td>
<td>33.3</td>
<td>11.8</td>
</tr>
<tr>
<td>Embarrassed if others knew I was seeking help for PTSD</td>
<td>7.8</td>
<td>27.5</td>
<td>26.5</td>
<td>28.4</td>
<td>9.8</td>
</tr>
<tr>
<td>Wasn’t good company</td>
<td>5.9</td>
<td>13.7</td>
<td>23.5</td>
<td>40.2</td>
<td>16.7</td>
</tr>
<tr>
<td>Inadequate around other people</td>
<td>5.9</td>
<td>21.6</td>
<td>25.5</td>
<td>35.3</td>
<td>11.8</td>
</tr>
</tbody>
</table>

Participants rated the extent to which they agreed with items measuring self-stigma related to PTSD. Frequencies of endorsement of items are presented in Figure 3.

Participants most strongly endorsed negative beliefs regarding their perceived capacity to manage their symptoms. For example, over 85% of the sample agreed or strongly agreed with the items “I should have been stronger” and “I should be able to ‘pull myself together’”.

Blaming oneself for symptoms was also highly prevalent, with 40% of the sample endorsing “I only had myself to blame” and 44% reporting that they were “Disappointed in myself”. Over 40% of the sample also endorsed feelings of shame or embarrassment in relation to their symptoms.

Participants also frequently endorsed negative social consequences associated with PTSD symptoms, for example that they “Wouldn’t want others to know they weren’t coping” (38%), perceiving themselves as “A burden to others” (34%), and that they “ Couldn’t contribute much socially” (37%).
Participants rated the extent to which they agreed with items indexing self-stigma related to help-seeking. Frequencies of endorsement of items are presented in Figure 4.

Compared to items indexing self-stigma related to PTSD, endorsement of self-stigma related to help-seeking was relatively lower. While 64% of the sample agreed or strongly agreed with the statement “I would feel worse about myself if I could not solve my own problems”, only 15% endorsed the statement “Seeking psychological help would make me feel less intelligent” and only 16% endorsed “It would make me feel inferior to ask a therapist for help”.

In contrast, 65% reported that “My self-confidence would not be threatened if I sought professional help” and 57% that “My view of myself would not change just because I made the choice to see a therapist”. Participants also recognised the potential benefits of seeking help, with 61% of the sample reporting that “My self-esteem would increase if I talked to a therapist”.
Participants indicated how likely they would be to seek help from a number of sources for a personal or emotional problem over the next four weeks. Frequencies of endorsement are presented in Figure 5.

First, it is notable that 44% of the sample reported that it was likely, very likely or extremely likely that they would not seek help in the next four weeks. Participants indicated that they would be most likely to seek support from informal help-seeking sources. The majority of participants (70%) indicated that they would be likely to seek help from a partner, while almost half (46%) stated that they would be likely to seek help from a friend.

In terms of formal help-seeking, participants stated they were most likely to seek help from a doctor (64%), followed by a mental health professional (50%), community leader (43%), religious leader (41%), or caseworker (41%).

<table>
<thead>
<tr>
<th>Source</th>
<th>Extremely Likely</th>
<th>Very Likely</th>
<th>Likely</th>
<th>Neutral</th>
<th>Unlikely</th>
<th>Very Unlikely</th>
<th>Extremely Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td>43.1</td>
<td>3.9</td>
<td>23.5</td>
<td>2</td>
<td>6.9</td>
<td>2.9</td>
<td>17.6</td>
</tr>
<tr>
<td>Doctor/GP</td>
<td>11.8</td>
<td>4.9</td>
<td>47.1</td>
<td>5.9</td>
<td>11.8</td>
<td>2.9</td>
<td>15.7</td>
</tr>
<tr>
<td>Friend</td>
<td>14.7</td>
<td>5.9</td>
<td>42.2</td>
<td>12.7</td>
<td>4.9</td>
<td>19.6</td>
<td></td>
</tr>
<tr>
<td>Other family member</td>
<td>9.8</td>
<td>3.9</td>
<td>40.2</td>
<td>2.9</td>
<td>11.8</td>
<td>1</td>
<td>30.4</td>
</tr>
<tr>
<td>Mental health professional</td>
<td>13.7</td>
<td>35.3</td>
<td>3.9</td>
<td>21.6</td>
<td>5.9</td>
<td>18.6</td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>15.7</td>
<td>5.9</td>
<td>25.5</td>
<td>2.9</td>
<td>11.8</td>
<td>2.9</td>
<td>35.3</td>
</tr>
<tr>
<td>Son/daughter</td>
<td>14.7</td>
<td>4.9</td>
<td>24.5</td>
<td>2.9</td>
<td>10.8</td>
<td>1</td>
<td>41.2</td>
</tr>
<tr>
<td>Teacher</td>
<td>4.9</td>
<td>36.3</td>
<td>2.9</td>
<td>20.6</td>
<td>4.9</td>
<td>27.5</td>
<td></td>
</tr>
<tr>
<td>Community leader</td>
<td>2.9</td>
<td>37.3</td>
<td>6.9</td>
<td>16.7</td>
<td>2.9</td>
<td>30.4</td>
<td></td>
</tr>
<tr>
<td>Caseworker</td>
<td>5.9</td>
<td>31.4</td>
<td>4.9</td>
<td>21.6</td>
<td>5.9</td>
<td>26.5</td>
<td></td>
</tr>
<tr>
<td>Religious leader</td>
<td>3.9</td>
<td>34.3</td>
<td>2</td>
<td>16.7</td>
<td>2</td>
<td>38.2</td>
<td></td>
</tr>
<tr>
<td>Would not seek help</td>
<td>11.8</td>
<td>4.9</td>
<td>27.5</td>
<td>4.9</td>
<td>20.6</td>
<td>2.9</td>
<td>27.5</td>
</tr>
</tbody>
</table>
Participants indicated whether they had sought help from a number of sources for a personal or emotional problem over the past two weeks. Frequencies of endorsement are presented in Figure 6. Participants were most likely to have sought help from informal help-seeking sources such as a partner (28%) or friend (25%). In terms of formal help-seeking, participants were most likely to have sought help from a doctor (10%), followed by a religious leader (4%) and a caseworker, teacher, or mental health professional (3%).
PHASE 2: DEVELOPING THE TELL YOUR STORY INTERVENTION

Background

Phase 2 focused on developing the content for the TYS intervention. Throughout this process, we aimed to consolidate the existing literature and the knowledge gained from our engagement with the target communities to develop an intervention that addressed the specific beliefs and concerns of each community. Working across three language groups and numerous cultural communities, care was taken to ensure the intervention used culturally relevant information, expressions and language. The intervention was translated into each of the target languages, then carefully refined with secondary translators and cultural advisors.

DEVELOPMENT OF THE INTERVENTION

INTERVENTION CONTENT

The TYS intervention was developed based on information regarding self-stigma and help-seeking derived from the qualitative interviews and consultations conducted in Phase 1. In addition, the content of the intervention was informed by evidence-based strategies that have been demonstrated to produce reductions in mental health stigma. These strategies comprised education, reappraisal and social-contact. In order to incorporate these strategies in a way that was amenable to online delivery, the intervention utilised 3 key components—information, videos, and activities/tasks.

Education. Tell Your Story aimed to provide information that addressed mental health stigma, targeting common beliefs, misperceptions and concerns about seeking help. This involved providing information on symptoms, contributing factors and rates of common mental health difficulties in refugee communities. Videos, stories, text and interactive activities all provided opportunities to correct stereotypes, increase mental health literacy and provide information about different forms of support.

Reappraisal. Throughout the intervention, stigma was explicitly discussed. The program normalised and validated common concerns, as well as provided information that challenged these beliefs. The videos, stories, text and interactive activities were all designed to aid the user to think more realistically about their own experiences, and the meaning and consequences of help-seeking, with the goal of challenging unhelpful beliefs. For example, in the video stories, refugee men talk about their initial negative beliefs about their own symptoms and concerns about seeking help. By explicitly discussing unhelpful beliefs, the program encouraged users to become aware of their own negative beliefs. By ensuring that the videos...
provided users with “contact” with men who also held these concerns prior to changing their perspectives, we encouraged users to relate to these positive examples of help-seeking. TYS also featured guided cognitive reappraisal activities in which users can directly challenge maladaptive beliefs about their symptoms and the meaning and consequences of help-seeking. This technique aimed to help participants to think more realistically about their symptoms and reduce negative emotional responses that were related to maladaptive beliefs about mental health.

Social Contact. To achieve the fundamental principle of social-contact using an online medium, TYS featured videos depicting men from participants’ own cultural groups and communities, speaking in their own languages about (i) their PTSD symptoms, (ii) how they overcame negative beliefs about mental health and (iii) their positive help-seeking experiences. In line with best practice, the TYS intervention facilitated targeted, local, credible and continuous contact between the user and individuals who had had positive help-seeking experiences. Given the digital format, we considered video, audio and written stories, quotes, photographs and user forums. Ultimately, we decided to make a series of short videos, accompanied by anonymised, amalgam quotes from the interviews we conducted. With guidance from our community advisors, we were able to ensure the video stories were culturally appropriate, sharing information about mental health and challenging common myths and misconceptions. The men in the videos use culturally appropriate expressions of distress to describe their symptoms, so as to enhance the relevance of the material for individuals from specific cultural groups.

These techniques were designed to work together to reduce mental health stigma and encourage participants to seek help for any emotional problems they may be experiencing.

INTERVENTION DESIGN AND TECHNOLOGY

The look and feel of the TYS intervention was designed to be simple and positive. We drew on the expertise of the Community Advisory Boards to ensure that the presentation of the intervention was appealing, engaging and culturally appropriate. The intervention was developed by the Black Dog Institute, using their existing online platforms. This involved the design of the intervention and assessment components and building new functionality for interactive activities. Creating an intervention that could be programmed in three languages with distinct features was challenging, and necessitated that the content, media and activities be kept simple to maximise flexibility.

LANGUAGE AND TRANSLATION

All aspects of the intervention were translated into study languages by accredited translators. All translations were also carefully reviewed and reconciled with a second translator, who also acted as cultural consultant. This allowed us to refine the translated content so that it was optimally culturally applicable. Given differences in literacy in the target populations, we
prioritised ensuring that appropriate literacy level was maintained in the intervention, while accurately reflecting the intended content.

Following advice from our Community Advisory Boards, we decided to avoid referring to “psychological symptoms” and “posttraumatic stress disorder” in the intervention. Instead, we focused on providing users with the opportunity to hear from other men regarding how they managed “stress”. This language extended to materials used to promote the study.

**VIDEOS**

A central component of this intervention were videos of refugee men from each of the communities speaking about their own beliefs about psychological symptoms and positive help-seeking experiences. Due to high levels of mental health stigma in these communities, identifying refugee men who were willing to speak openly about their psychological symptoms was challenging. We were extremely fortunate that six refugee men (two from each community) who had overcome psychological symptoms were willing to talk about their experiences on-camera to help others. This process was greatly facilitated by working with film-makers with expertise in working with culturally-diverse and vulnerable populations.

### Objectives

1) To determine the cultural appropriateness of the information, videos and activities used in the TYS intervention for Arabic, Farsi and Tamil-speaking refugees.

2) To elicit feedback on functionality and usability of the site.

3) To evaluate the extent to which materials and activities on the site were engaging for potential participants.

### Methodology

Eleven Community Advisory Board members used the TYS program and provided feedback on each module (activities, videos, and content). Following completion of the program each member was interviewed by telephone.

### Findings

Key points that arose from the qualitative interviews were:

- **Chapters should be shorter and more easily accessible to promote engagement with the program.** On the basis of this feedback, a twelve-session intervention was developed, rather than an intervention that featured four long sessions as initially planned. This enabled each session or ‘chapter’ to be much shorter and more easily accessible,
particularly when using a smart phone device to access the program.

- **Informal help-seeking** modules should be amended. Participants in the qualitative interviews recommended focusing on formal and professional help-seeking strategies (i.e., community leaders, health professionals) to reduce the possibility of negative responses towards our participants arising from public stigma. Accordingly, we increased the content of the program that focused on formal help-seeking opportunities. The modules on informal help-seeking were amended to focus on helping men to identify people who they trust with whom to discuss their difficulties rather than the promoting the sharing of their stories more broadly.

- **Participants identified particular tasks as too difficult.** These tasks were simplified in order to promote ease of use.

- **Include visual material throughout.** More visual material (i.e., pictures and diagrams) was added throughout the intervention to promote participant engagement.

In response to this feedback, we were able to carefully refine the intervention before launching the TYS program. The TYS program was adapted to be used on either a computer or smartphone, using an existing web-based platform hosted by the Black Dog Institute. This involved some significant changes to the content as we reconsidered how to present information most effectively and redesigned some of the key interactive elements of the program. A detailed outline of the program layout and module content follows.
Chapter 1: Welcome

- Users watch videos and are introduced to the men that they follow throughout the course of the program. This chapter aims to increase motivation to enter the program.
- Users learn about the experiences of other refugee men (social contact).

Chapter 2: TYS video case studies

- This chapter provides detailed introductions to the refugee men that will be followed throughout the program.
- Past experiences and current living difficulties faced by users are normalised (social contact and education).
Chapter 3: Surviving stress

- Users learn about how traumatic experiences and stress can impact day to day life (education).
- This chapter provides an overview of common symptoms that can occur as a result of stress or previous traumatic experiences (education).

Chapter 4: How does stress affect me?

- Users learn about the symptoms experienced by refugee men via video case studies (education & social contact).
- This chapter guides participants through identifying what their own symptoms of stress/trauma might be (education).
Chapter 5: Growing stronger

- This chapter normalises PTSD symptoms (*education*).
- Users identify their own negative beliefs about their symptoms.
- Users challenge their own negative beliefs about psychological symptoms (*reappraisal*).

Chapter 6: Keeping it all Inside

- Users see the men in the videos express their own concerns about seeking help (*social contact*).
- Users identify their own help-seeking concerns.
Chapter 7: I’d like to talk, but...

- Users challenge their own help-seeking concerns (reappraisal).

Chapter 8: How can talking help

- Users learn about how things changed for refugee men in the videos once they were able to share their experiences with someone they trust (social contact).
- Users identify the potential benefits of talking about their problems.
Chapter 9: Who could I talk to?
- This chapter helps users identify suitable people to talk to and share concerns and experiences with (e.g., a trustworthy family member, friend, or a professional).
- Users learn about different professional roles and how each professional may be able to help them (education).

Chapter 10: Advice for X
- Users work through a ‘case example’ of a refugee man with a similar background who is struggling with stress (social contact).
- Users complete an activity in which they help this man challenge his negative beliefs/stigma about mental health problems.
Chapter 11: Planning action

- This chapter provides an overview of the user’s own most salient stigma and help-seeking concerns.
- Users complete an activity in which they identify the challenges and benefits to help-seeking.
- Users develop a personalised plan of action for help-seeking.

Chapter 12: Summary of progress through the intervention

- Users revisit their plan of action.
- Users watch summary video of refugee men in the video case studies to increase motivation moving forward.
PHASE 3: EVALUATING THE TELL YOUR STORY INTERVENTION

Background

A randomised controlled trial was conducted to evaluate the efficacy of the TYS intervention in reducing self-stigma and increasing help-seeking intentions and behaviours in refugee men. Participants were randomly assigned to either take part in the intervention (TYS) or to a wait-list control (WLC) group. The wait-list control arm was included in this study to determine the extent to which the TYS intervention led to improved outcomes over and above natural change in stigma over time and following contact with the research team.

Objectives

To evaluate the efficacy of the TYS intervention in:

1) Reducing self-stigma related to PTSD.
2) Reducing self-stigma related to help-seeking.
3) Increasing intended help-seeking behaviours.
4) Increasing actual help-seeking behaviours.

Methodology

RECRUITMENT

Participants were recruited into the study via four key pathways, including promotion of the study by Settlement Services International, referrals from other refugee service providers in NSW, direct community engagement (i.e., radio interviews, talks to community groups) and online advertising (i.e., Facebook).

Promotion of the intervention at Settlement Services International (SSI)

Our partner organisation SSI were heavily involved in the recruitment process. The TYS program was described to SSI clients and information about the program was distributed. Those clients that expressed an interest in using the TYS program were contacted by the research team. Presentations were also held for SSI staff explaining the benefits of using the TYS program for refugee men and for the sector more broadly. Therefore, caseworkers were familiar with the TYS program and consequently were able to answer questions that arose regarding the program.
Referrals from other service providers

This referral pathway involved drawing on established relationships with key organisations in the refugee sector and identifying ambassadors within each organisation to help internally promote the intervention to staff and their clients. We worked carefully with members of these organisations to better understand how TYS could benefit them and their clients. Promoting TYS to service providers in the refugee sector more broadly enabled us to maximise the number of referring organisations, capture refugees with more diverse experiences, and increase the number of referrals.

It is notable that services in the refugee sector were overwhelmingly positive about the TYS intervention, stating that it addressed a critical gap in the available resources for refugee groups. One difficulty identified by several service providers is the relatively low level of uptake of referrals for specialist mental health services. It was reported that TYS directly addressed some of the critical barriers to help-seeking.

Paid online advertisements

Paid advertisements providing details about the TYS intervention and research participation were posted on Facebook and Instagram. These advertisements were presented in language and were targeted to only appear to men, aged over 18 years old, who spoke Arabic, Farsi, or Tamil languages. Furthermore, the images used were wherever possible tailored to suit each cultural group. These advertisements were useful in increasing our reach and allowing us to promote the TYS intervention Australia-wide. These advertisements linked to the TYS website where interested individuals could read, watch videos about the TYS program in their language, and sign-up using a designated self-referral link.

Direct community engagement

Engaging with ethnic media, radio interviews were held on popular Tamil radio shows to promote the TYS program amongst this community. Information about the TYS program was also presented at public community lectures and talks to local community groups.

SCREENING

A screening phone call was conducted to determine eligibility (using an interpreter whenever necessary). The inclusion criteria were:

1. Male with a refugee background residing in Australia
2. Aged between 18 years and 65 years old
3. At least one core symptom of PTSD
4. Not currently suicidal
5. Not regularly seeing a psychologist/ mental health professional

Eligible participants were sent an email with a link to access the TYS website, where they,
provided informed consent, and created their own personal account.

**STUDY DESIGN**

Participants were randomised to the TYS or WLC group following completion of the baseline assessment measures. Participants were provided with access to the 12-module TYS program for 4 weeks. Modules 1-4 were released in the first week, 5-8 in the second week, and 9-12 in the third week. See figure 7, on the following page, for a detailed diagram representing the study design. Emails, postcards and phone calls were used to remind participants to complete assessment points. Following completion of the wait-list period, participants in the WLC condition were given access to the program.

**ASSESSMENT**

All participants completed assessment measures at baseline, one month after baseline (post-treatment assessment for those in the intervention condition), and two months after baseline (one-month follow-up for those in the intervention condition). Participants were provided with a $20 gift voucher after completing each online survey. Constructs measured, scales and time-points at which they were administered are presented in Table 2.

**Table 2. Constructs measured and scales used at different assessment points**

<table>
<thead>
<tr>
<th>Construct</th>
<th>Measure</th>
<th>Screening</th>
<th>Baseline</th>
<th>Post-intervention (1 month)</th>
<th>Follow-up (2 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic information, refugee status, suicidality</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-migration trauma exposure</td>
<td>Harvard Trauma Questionnaire</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Molfica et al., 1992)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-migration living difficulties</td>
<td>Post-migration Living Difficulties Checklist (Steele et al., 1999; Slave et al., 1997)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptability and usability of intervention</td>
<td>Questionnaire developed for study</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD symptoms</td>
<td>Posttraumatic Stress Diagnostic Scale (Foa et al., 1997; Foa, 1996)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Physical &amp; Mental health-related quality of life</td>
<td>SF-12 Health Survey (short-form) (Gandek et al., 1998; Ware, Kosinski, &amp; Kasper, 1996)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Self-stigma related to PTSD</td>
<td>Self-Stigma for Depression Scale (adapted to PTSD) (Barney et al., 2010)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Help-seeking intentions</td>
<td>General Help-Seeking Questionnaire (Deane, Wilson, &amp; Carroll, 2001)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Help-seeking behaviours</td>
<td>Actual Help-Seeking Questionnaire (Rickwood et al., 2005)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Figure 7. Tell Your Story study design

- Screening call
- Complete baseline registration
- Randomisation
- Intervention group
- Waitlist group
- 4 weeks access to 12 online modules
- WAIT for 4 weeks
- Post-wait measures
- Automated email
- Post-card if late to complete
- Automated email when modules released
- Reminder SMS/call if still late
- 1 month follow-up measures
PARTICIPANTS

A detailed representation of participant flow through the study is presented in Figure 8 below. 688 participants had expressed interest in the program and had been screened for eligibility (with telephone interpreters used for approximately 79% of the screening calls). Of these, 149 were eligible to participate, and 102 had completed baseline assessment measures. Of these, 53 were in the TYS group and 49 in the WLC group. At the time of this report, 81 participants had completed post-treatment assessment, of which 44 were in the TYS group and 37 in the WLC group. 73 participants had completed the follow-up assessment, of which 38 were in the TYS group and 35 in the WLC group. 63 participants had completed all three assessment points. At both the post- and follow-up assessment there are participants still progressing through the time-points.

Figure 8. Participant flow through the study

REASONS FOR INELIGIBILITY

Of the 688 individuals referred, 375 were able to be contacted and screened for entry into the study. Of these, 149 individuals were eligible to participate. The most common reasons for potential participants being ineligible were as follows:

- Not speaking one of the study languages
- Unstable living conditions (i.e., recently arrived in Australia and not yet secured housing)
- Inability to access the internet (i.e., recently arrived in Australia and do not yet have internet access)
Current suicidal ideation or intent
No current PTSD symptoms
Already seeking professional assistance for PTSD symptoms

BARRIERS TO COMPLETING BASELINE ASSESSMENT

Of the 149 eligible participants, 102 completed the baseline assessment, with 47 participants failing to complete this assessment. The most common reasons for participants not completing the baseline assessment were:

- Technical issues (i.e., internet access not consistent)
- Low computer literacy (i.e., difficulty setting up an account, accessing the intervention)
- Unstable living conditions (i.e., moved house and no longer have access to the internet)
- Current life circumstances (i.e., waiting for decision on asylum application)

To overcome these barriers, the following steps were taken:

- Development of a simple user guide in study languages explaining how to access the intervention (i.e., how to create account and login etc.).
- Send automatic emails to prompt completion of baseline
- Send reminder postcards to participants’ home address
- Send SMS text reminders
- Individual phone calls to trouble-shoot difficulties with website

ANALYSIS

Descriptive statistics, such as frequencies and mean scores, are presented in relation to all measures. To examine the effectiveness of the TYS intervention, repeated measures analyses of variance (ANOVAs) were conducted with participants who had completed all three timepoints. All analyses were conducted using SPSS v24 software and setting $\alpha = .05$. 
Findings

DEMOGRAPHICS

Data presented here was elicited from the 102 participants who have completed baseline measures. Participants were from Arabic (n = 79), Farsi (n = 17) or Tamil (n = 6)-speaking backgrounds, with 77% of the sample having been born in Iraq or Syria (see Figure 9).

Participant ages ranged from 18 years old to 64 years old and the average age was 40.05 years old (see Figure 9).

Figure 9. Country of birth and age demographics

The high representation of Arabic-speaking participants reflects the fact that these groups represent the majority of refugees that are currently resettling in Australia. In contrast, there was relatively low participation from the Tamil community despite a comprehensive engagement strategy including working with community leaders, a Tamil radio interview, and language-specific Facebook advertisements. Tamil-speaking community leaders identified key barriers to participation as being lower level of computer access, computer literacy and written literacy.

PAST EXPERIENCES - TRAUMA EXPOSURE

Participants reported having experienced an average of 4.8 types of traumatic events, with a range of 0 to 13. Commonly experienced traumatic events included being close to death (63% of the sample), lack of food or water (49%), witnessing the murder of a family member or friend (31%) and being tortured (22%).
CURRENT EXPERIENCES - POST-MIGRATION LIVING DIFFICULTIES

Participants reported having experienced an average number of 11.3 living difficulties over the past 12 months, with a range of 0 to 29. The most significant problem was ‘worry for family back home’ identified by 74.5% of the sample. Other problems such as ‘being unable to return home in an emergency’ (68.6%), ‘difficulties with the family reunion process’ (64.7%), ‘not being able to find work’ (59.8%), and ‘difficulties finding housing’ (51%) were identified as significant problems by more than half the sample.

Figure 10. Symptoms of Posttraumatic Stress Disorder

Participants indicated how frequently they had experienced symptoms of PTSD over the past months. The ten most frequently endorsed symptoms are presented in Figure 10. Total scores on this measure above 21 are indicative of severe PTSD and those above 11 indicate mild PTSD (Winters et al., 2014). The average severity rating for participants was 20.3, suggesting that symptom levels were high in the current sample.

TELL YOUR STORY IN-PROGRAM FINDINGS

Participants in the TYS group completed activities indexing their beliefs about mental health, their concerns about help-seeking, the potential benefits of talking to someone, and who might be a suitable person to talk to. The findings from these activities are presented in this section and are based on those participants in the TYS group only (n=53).
In Chapter 5, users were asked to rate the extent to which they agreed or disagree with some commonly held beliefs about mental health. 22 TYS users completed this activity. The findings are shown in Figure 11 above. The majority of men that completed this activity disagreed with the negative beliefs about mental health presented in this questionnaire. 18% of users ‘agreed’ or ‘slightly agreed’ with the belief that ‘Being stressed like this means I cannot contribute to my community’, and that ‘I cannot recover from the negative effects of my past’.
In Chapter 6, users identified their concerns about seeking help (see Figure 12). 18 TYS users completed this activity. The most commonly held concern about seeking help was ‘Whoever I talk to might judge me’, with which 27.8% of users ‘agreed’ or ‘slightly agreed’. This was followed by ‘I have no idea where to get the sort of support I need’, ‘Sharing my stress with my friends would only burden others’, and ‘Suffering is a test and I should shoulder it alone’, endorsed by 22.2% of users.
Figure 13. Benefits of talking

In Chapter 8, users watched videos of men sharing their positive experiences of talking with someone about their problems. They then completed an activity where they identified the potential benefits of talking (see Figure 13). This activity was completed by 18 users.

The most commonly endorsed benefits were ‘Talking could release the pressure I feel inside’ (61.1%) and ‘It could feel good to talk to somebody who understands’ (61.1%). In addition, participants frequently endorsed potential benefits for others, including ‘By doing this, I could learn how to best advise others with similar problems in the future’ (44.4%).
In Chapter 9, users were asked to think about a suitable person they could talk to (see Figure 14). 13 users completed this activity. Informal sources of support, such as friends or family members, were ranked the highest. It is notable that 30% of participants also ranked seeing a psychiatrist or counsellor/psychologist first or second.

**TELL YOUR STORY INTERVENTION FINDINGS**

The following findings report on the impact of the TYS intervention on primary outcome measures including self-stigma related to PTSD, self-stigma associated with seeking help, help-seeking intentions, and actual help-seeking behaviours. Findings related to the secondary outcome measures of quality of life and symptoms of PTSD, are also presented. These findings are based on those participants that have completed the three assessment points at the time of this report (n=63).

**SELF-STIGMA RELATED TO PTSD**

Participants completed the Self-Stigma for PTSD Scale (an adapted version of the Self-Stigma for Depression Scale). This scale comprises four sub-scales, notably social inadequacy, help-seeking inhibition, shame, and self-blame. Analyses were conducted to determine whether use of the TYS intervention led to greater reductions in self-stigma related to PTSD in the intervention group compared to the WLC group.
Figure 15. Social inadequacy subscale of the self-stigma for PTSD scale

Individuals in the TYS group showed significant decreases in feelings of social inadequacy associated with PTSD, from post-intervention to follow-up ($t=2.29$, $p=0.025$). The WLC group did not decrease in social inadequacy across time (baseline to post-intervention, $t=1.36$, $p=0.178$; post-intervention to follow-up, $t=0.36$, $p=0.722$) (see Figure 15).

Figure 16. Help-seeking inhibition subscale of the self-stigma for PTSD scale

The TYS group showed a significant decrease in help-seeking inhibition associated with PTSD, from baseline to follow-up ($t=3.80$, $p<0.001$) and from post-intervention to follow-up ($t=2.43$, $p=0.018$). The WLC group did not decrease in help-seeking inhibition (baseline to post-intervention, $t=1.03$, $p=0.306$; post-intervention to follow-up, $t=0.26$, $p=0.794$) (see Figure 16).
Individuals in the TYS group showed a significant decrease in feelings of shame associated with PTSD, from baseline to post ($t=2.85$, $p=0.006$) and from baseline to follow-up ($t=2.58$, $p=0.012$). The WLC group, however, did not decrease in terms of feelings of shame across time (baseline to post-intervention, $t=0.69$, $p=0.491$; post-intervention to follow-up, $t=1.07$, $p=0.291$) (see Figure 17).

The TYS group showed a significant reduction in feelings of self-blame associated with PTSD from baseline to post-intervention ($t=2.25$, $p=0.028$). The WLC group showed a significant reduction in self-blame from baseline to post-intervention ($t=2.20$, $p=0.032$), and from baseline to follow-up ($t=1.07$, $p=0.291$) (see Figure 18).
to follow-up ($t=3.20, \ p=0.002$) (see Figure 18).

**SELF-STIGMA FOR SEEKING HELP**

Participants completed the Self-Stigma of Seeking Help Scale to index their levels of stigma associated with help-seeking behaviours. Analyses were conducted to determine whether use of the TYS intervention led to greater reductions in self-stigma related to help-seeking in the intervention group compared to the WLC group.

**Figure 19. Scores on the self-stigma of seeking help scale**

The WLC group showed a significant increase in self-stigma for seeking help from baseline to follow up ($t=2.12, \ p=0.039$) and from post-intervention to follow-up ($t=2.60, \ p=0.012$). In contrast, there were no increases in self-stigma for seeking help for those in the TYS group across time (baseline to post-intervention, $t=0.81, \ p=0.421$; post-intervention to follow-up, $t=0.28, \ p=0.780$) (see Figure 19).
HELP-SEEKING INTENTIONS

Participants completed the General Help-Seeking Questionnaire to index how likely they were to seek help from a number of different sources over the following four weeks. These sources of support were grouped into: Formal help-seeking, including GP/doctor, mental health professional, and caseworker; Informal help-seeking, including, parent, spouse/partner, friend, son/daughter, or other family member; and Community help-seeking, including, community leader, teacher, and religious leader. Analyses were conducted to determine whether use of the TYS intervention led to greater increases in intended help-seeking in the intervention group compared to the WLC group.

Figure 20. Intended formal help-seeking

The WLC group showed a significant increase in intended formal help-seeking from post-intervention to follow-up ($t= 2.05, p=0.045$). However, there was no significant change in formal help-seeking intentions in the TYS group (baseline to post-intervention, $t=0.20, p=0.843$; post-intervention to follow-up, $t=1.80, p=0.077$) (see Figure 20).

There was no significant change in informal or community help-seeking intentions in the TYS group or WLC group.
HELP-SEEKING BEHAVIOUR

Participants completed the Actual Help-Seeking Questionnaire to index the extent to which they had sought help from formal and informal sources over the past two weeks. These sources of support were grouped into: Formal help-seeking, including GP/doctor, mental health professional, and caseworker; Informal help-seeking, including, parent, spouse/partner, friend, son/daughter, or other family member; and Community help-seeking, including, community leader, teacher, and religious leader. Analyses were conducted to determine whether use of the TYS intervention led to greater increases in actual help-seeking in the intervention group compared to the WLC group. Further analyses were conducted to examine the relationship between new sources of support accessed by participants and the number of modules completed in the TYS intervention.

Figure 21. Informal help-seeking sources (e.g., family members and/or friends)

The TYS group showed a significant increase in number of informal help seeking sources accessed from baseline to post intervention ($t=2.56, p=0.013$) (see Figure 21). There was no change in access of informal sources of support for the WLC group (baseline to post-intervention, $t=0.88, p=0.380$; post-intervention to follow-up, $t=0.73, p=0.466$).

There was no significant change in informal or community help-seeking intentions in the TYS group or WLC group.
These findings are based on the 38 participants that were in the TYS group and had completed the follow-up assessment point. The findings show that those who completed 11 modules sought help from significantly more new sources of support at follow-up compared to those who had completed fewer modules ($F(3,32)=3.46, \ p=0.028$).
SECONDARY OUTCOMES

QUALITY OF LIFE

Participants completed the SF-12 Health Survey to index both their physical and mental health related quality of life.

Figure 23. Physical health related quality of life

![Graph showing quality of life over time]

The TYS group showed significantly better physical health related quality of life at follow-up than the WLC group ($t=2.34, p=0.023$) (see Figure 23). There was no significant change in mental health-related quality of life in either group over time.
SYMPTOMS OF PTSD

Participants completed the Posttraumatic Stress Diagnostic Scale to index the severity of their PTSD symptoms. Analyses were conducted to determine whether use of the TYS intervention led to greater reductions in PTSD symptom severity in the intervention group compared to the WLC group.

Figure 24. Symptoms of PTSD

The TYS group showed a significant decrease in PTSD symptoms from post-intervention to follow-up ($t=2.95, p=0.005$) (see Figure 24). The WLC group did not show any change in PTSD symptoms (baseline to post-intervention, $t=1.22, p=0.226$; post-intervention to follow-up, $t=0.40, p=0.687$).
TELL YOUR STORY PROGRAM USER EXPERIENCE

Participants in the TYS group provided information on their experience of using the program across a number of different areas including access, ease of use, and the acceptability of the information, videos, and activities.

ACCESS

The most common device used to access the TYS program was a smartphone, with 62.8% of participants using TYS on a smartphone, 32.6% on a computer/laptop and 4.7% on a tablet.

EASE OF USE

Participants rated the extent to which they found the program to be easy to use. The proportion of the sample that endorsed each response option is presented in Figure 25.

**Figure 25. How easy was the program to use?**

![Pie chart showing ease of use ratings]

Overall, the majority of participants rated the program as ‘very easy’ or ‘easy’ to use on their device, with no participants reporting that the TYS program was difficult to use.

PREFERRED COMPONENTS OF THE TELL YOUR STORY PROGRAM

Participants were asked which of the three components used in the TYS program they preferred: information, videos, or activities/tasks. 60.5% of participants stated they preferred information, 34.9% videos and 4.7% activities/tasks.
USEFULNESS AND RELEVANCE OF INFORMATION PRESENTED IN PROGRAM

Participants also rated how useful and how relevant they found the information presented in TYS. The proportion of participants who endorsed each response option is presented in Figures 26 and 27 below.

Figure 26. Usefulness of information

[Pie chart showing 76.7% rated quite useful, 11.6% quite a bit, and 11.6% a little bit.]

Figure 27. Relevance of information

[Pie chart showing 37.2% rated quite relevant, 51.2% quite a bit, and 4.7% a little bit.]

The majority of users rated the information presented in the TYS program as ‘quite’ useful and relevant.

VIDEOS

Eight videos were presented as part of the TYS program. Videos were presented in participants’ own language and featured refugee men talking about their experiences with mental health and help-seeking. TYS users were asked to rate how interesting they found the videos to be (see Figure 28).

Figure 28. How interesting were the videos?

[Pie chart showing 60.5% strongly agree, 23.3% agree, 2.3% neutral, 14% disagree, and 2.3% strongly disagree.]

74.5% of the sample reported that they agreed or strongly agreed that the videos were interesting.
PARTICIPANT ENGAGEMENT

To index how engaged participants were with the program, we recorded how many users completed each of the modules (see Figure 29), and how many modules users completed overall (see Figure 30). Note: This data is based on the subset of users that have completed their 12 week access to the TYS program (n= 53).

Figure 29. Percentage of users that have completed each module

![Figure 29. Percentage of users that have completed each module]

Figure 30. Total number of modules completed

![Figure 30. Total number of modules completed]

Overall, the majority of TYS users completed either 3 modules (30.2%) or all 11 modules (20.8%). The first 3 modules were completed by the highest number of users followed by modules 4 to 7. Given that modules 4-12 remained locked to the users until the beginning of the second week of access, this suggests that users were most engaged with the program during the first week.
KEY INSIGHTS FROM THE TELL YOUR STORY PROJECT

Understanding Self-Stigma in Refugee Men

- **Self-stigma related to mental health and help-seeking represents an important barrier to help-seeking for refugee men.** Self-stigma related to PTSD, in particular, was highly prevalent amongst the study sample, with many men reporting negative beliefs about their capacity to manage psychological distress, as well as fear of social consequences of others finding out about their symptoms.

- **Cultural beliefs about mental health may contribute to self-stigma related to mental health and reduced help-seeking.** The perception that experiencing psychological symptoms is indicative of extreme mental illness and may lead to inability to function in one’s daily life contributes to negative beliefs about mental health. In addition, a common theme that emerged in this project was fear of negative responses from one’s community if psychological symptoms are disclosed.

- **Feelings of shame or guilt associated with the refugee experience may exacerbate self-stigma in refugee men.** Shame or guilt associated with traumatic experiences and post-migration stressors may increase negative perceptions of the self, particularly when experiencing PTSD symptoms.

- **The belief that talking is not useful may reduce the likelihood of help-seeking.** Many refugees are faced with significant practical challenges in their everyday lives. Talking about mental health difficulties may not seem helpful when an individual is having difficulty meeting his financial needs, or is worried about his family back at home. Some people reported being concerned that talking about mental health difficulties might make symptoms worse.

- **Difficulty trusting others may contribute to reluctance to seek help.** Specifically, difficulty trusting authority figures and others in the community may arise from past experiences, and reduce the likelihood that an individual will seek help for psychological symptoms.

- **Informal sources of support (e.g., partner or friend) were viewed most favourably by participants.** While findings from qualitative interviews indicated that disclosing psychological symptoms to the broader community may elicit negative responses, participants identified trusted individuals as those with whom they would be most likely to discuss mental health difficulties. However, only one-quarter of the sample had sought support from these sources in the past two weeks.
Participants also indicated a willingness to access formal sources of support. Participants reported that they would be willing to seek support from professionals such as doctors, caseworkers, mental health professionals, community and religious leaders. However, very few participants (less than 15%) had sought support from these sources in the past two weeks. In addition, over a third of participants who took part in the intervention stated that they didn’t know where to access appropriate support.

**Reducing Self-Stigma in Refugee Men**

- The TYS intervention was effective in reducing shame, help-seeking inhibition and feelings of social inadequacy in refugee men with PTSD. In addition, participants who took part in the TYS intervention showed significantly better physical health-related quality of life at follow-up.

- Refugee men who took part in the intervention also sought help from more informal help-seeking sources than those who were in the WLC group, with the number of help-seeking sources increasing with the number of modules the participants completed.

- Participants in the WLC group showed significant reductions in self-blame and increases in intended help-seeking from formal sources over the course of the study. This suggests that there may be natural improvements in self-stigma and help-seeking over time without intervention. It is possible that this was fostered by contact with the research team.

- The TYS intervention drew from evidence-based strategies including psychoeducation, reappraisal and social-contact. Participants reported that the information aspects of the program were most useful. This is consistent with reports that many participants did not know where to seek help. Participants also reported that the videos featured in the intervention were interesting and relevant for them.
RECOMMENDATIONS

Interventions Targeting Self-Stigma in Refugee Men

- There is a need for further research investigating mental health stigma and help-seeking in refugees from a variety of backgrounds.
- Interventions should draw on evidence-based principles. Findings from this study suggest that social contact and psychoeducation were effective in engaging refugees in the TYS program.
- It is critical to specifically tailor interventions to the experience and cultural backgrounds of the target communities.
- It may be useful for interventions to focus on self-stigma related to PTSD, and concerns about social consequences of help-seeking, rather than personal negative beliefs about help-seeking.

Project Learnings

PARTICIPATORY DESIGN

- Working with community advisory groups and/or cultural consultants is crucial to ensure that interventions and the research process are optimally sensitive, relevant and culturally appropriate.
- When engaging refugees to reduce mental health stigma, it is important to partner with refugee service providers. This partnership will facilitate the sharing of important information and greatly enhance the real-world utility of the intervention. In addition, the integration of stigma reduction programs such as TYS into refugee support services may increase the effectiveness of these interventions by removing important practical barriers to help-seeking.

MARKETING

- Promotion of an intervention with refugee groups takes time. For future projects, it would be beneficial to have a longer lead-time for promoting and evaluating interventions of this type.
- Refugee communities vary considerably in the way they engage with research projects and online interventions. Individual promotion and recruitment strategies are necessary for different cultural groups.
INTERVENTION DESIGN

- The adaptation of an existing online platform to specific target groups is efficient in terms of minimising time taken for design and programming. This may allow the intervention to be available in a more timely manner.

- Translating and programming an intervention into multiple languages introduces numerous challenges, and requires substantial resources and time. It is useful to design simple and flexible content to facilitate adaptation across languages.

Next Steps

- Future research should test TYS in an uncontrolled trial to determine its real-world effectiveness. It would also be beneficial to include a longer follow-up period to determine whether improvements following the program endure over time.

- Services identified a need for the development and dissemination of stigma reduction resources amongst caseworkers and other professionals.

- Providing plain language printed resources on stigma reduction would be beneficial to overcome barriers related to computer access and literacy.
REFERENCES


