“THEY SMILE BUT IT’S NOT REAL”:

KAREN REFUGEES’ PERCEPTIONS OF DEPRESSION

by

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ABSTRACT

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Refugees often carry with them traumas and mental health issues, which may continue or worsen in their new resettlement country. Understanding refugee populations and their mental health needs is a critical endeavor to support them effectively during and after the resettlement process. Currently, there is a lack of research over this population's mental health and what kinds of interventions are most effective. Recently, the U.S. has resettled a proportionately high number of refugees from Burma or Myanmar, mostly from the ethnic minority group called Karen. The present study interviewed 16 Karen refugees who were receiving medical care or case management at a clinic in north Texas. Participants were interviewed about their perceptions of depression and how best to help Karen people with depression. Findings revealed that Karen refugees tend to view depression as experiencing emotional distress, cognitive impairment, relationship difficulties, or somatization. Their recommendations include providing emotional support or practical solutions, increasing communication and awareness about depression, improving coping skills and health, turning to spirituality, or a combination.

Effective treatment may incorporate communal, problem-solving, or religious aspects.

Implications for future research, practice, and social work education are discussed.

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"They Smile But It's Not Real": Karen Refugees' Perceptions of Depression

Over three million refugees have resettled in the United States since Congress passed the Refugee Act of 1980 (Krogstad & Radford, 2017). In recent years, one of the largest groups has come from Burma (also known as Myanmar) to escape ongoing persecution and human rights violations (Kim, 2018; Office of Refugee Resettlement, 2013). Between 2008 and 2014, Texas received more Burmese refugees than any other state did, followed by New York (16,689 or 14.2% compared to 10,300 or 8.7%) (Worldwide Refugee Admissions Processing System, 2014). Also during this time period, Texas received more refugees from Burma than from any other country (U.S. State Department, 2017). Among refugees resettled in the U.S. from Burma, an ethnic minority called the Karen constitute the majority (Centers for Disease & Control Prevention [CDC], 2016).

Refugees are by definition fleeing persecution, war zones, human rights violations, and generalized violence, where they may have witnessed or experienced highly traumatizing events (Porter & Haslam, 2005; United States Citizenship & Immigration Services, United Nations High Commissioner for Refugees, 2012). After escaping these conditions, refugees may be left with posttraumatic stress disorder, depression, anxiety, demoralization, or other mental health problems (Briggs & Macleod, 2006; Kim, 2018). After arriving in the United States, everyday tensions from migration and acculturation stressors may lead to further mental health strain (Silove, Ventevogel, & Rees, 2017).

Even though some resources exist to help individuals cope with mental health conditions, refugees often face barriers to accessing care, such as cultural differences, unemployment, and a lack of social support (Miller & Rasmussen, 2010; Trieu & Vang, 2015). One of the most commonly discussed barriers to accessing care is the stigma associated with mental illness

(Shannon, Wieling, McCleary, & Becher, 2015; Shannon, Wieling, Simmelink-McCleary, & Becher, 2015). Another significant barrier is the inability to understand or speak English; this obstacle may leave refugees unable to report mental health symptoms and less likely to benefit from Western interventions (Mitschke, Praetorius, Kelly, Small, & Kim, 2017; Simich, Hamilton, Baya, & Neuwirth, 2004). Mental health symptoms may then worsen or go untreated (Hoffman & Robertson, 2016; Mullany et al., 2007). To date, little is known about barriers to mental healthcare that Burmese refugees face (Kim, 2018).

Correspondingly, few studies have been conducted over the severity of behavioral health symptoms among refugees from Burma or about viable treatment modalities for this population (Kim & Keovisai, 2016). Furthermore, even less is known about the perspectives of Burmese refugees on mental health (Fellmeth et al., 2015; Power & Pratt, 2012). As Trieu and Vang (2015) state, "Understanding a population is the critical first step to facilitating better educational opportunities, subsequently leading to the reduction of poverty and to better life chances and outcomes, for current and future generations" (p. 367). Due to the scarcity of research on this group and corresponding topic, the author sought to explore the perceptions of depression among recently resettled Karen refugees from Burma.

Literature Review

History

Burma has been plagued with interethnic civil war ever since gaining independence from British colonizers in 1948 (Walton, 2015). In more recent decades, the conflict has been between the militant government and ethnic minorities or groups demanding democracy (Trieu & Vang, 2015). Many Karen, Burma's second largest ethnic group, were targeted for ethnic and religious reasons and fled to Thailand and Malaysia (Kim & Kim, 2014; Sawe, 2018; World

Relief Fort Worth, 2014). Despite a ceasefire in 2004 between the Karen and the government, persecution and human rights violations continue (World Relief Fort Worth, 2014). These conflicts have led to a dramatic rise in Burmese refugees: from 2000 to 2015, the Burmese population in the U.S. grew from an estimated 17,000 to 168,000, making them the largest group resettled during that time (Kim, 2018; Lopez, Cilluffo, & Patten, 2017). During the second half of that time period, the highest percentage of Burmese refugees were Karen (CDC, 2016).

Mental Health of Burmese Refugees

John Tinpe, commissioner for the District of Columbia Commission on Asian and Pacific Islander Affairs, notes that although all refugees have the same basic needs, Burmese refugees have a lesser known culture, which isolates them from their communities (as cited in Trieu & Vang, 2015). This isolation is compounded by the fact that languages from different Burmese groups may be mutually unintelligible (World Relief Fort Worth, 2014). The risk for mental health distress is especially high for Karen people (George, 2010; Kim, 2018). As a persecuted minority in Burma, the Karen received less privilege, education, and social capital and had lower language literacy (Kim, 2018). Many were confined to refugee camps in Thailand for over 30 years, and only some camps provided education and job training (Burma Link, 2015). The Karen therefore tend to face lower socioeconomic outcomes and greater stress in their new host countries (Trieu & Vang, 2015).

In a systematic review of Karen refugees' physical and mental health, Hoffman and Robertson (2016) found that acculturative difficulties are significant contributors to mental and physical health decline. Hoffman and Robertson (2016) also point out that Karen refugees who experienced trauma and forced relocation face an even higher risk of mental and physical health regression. One study of 179 Karen refugees reported that 86% had endured war trauma, 52%

had endured secondary torture, and 27% had endured torture (Simmelink McCleary, Shannon, Im, & Cook, 2013). Many Karen people have suffered human rights abuses such as "forced labor, village burnings, arbitrary taxation, rape, and extrajudicial killings" (World Relief Fort Worth, 2014, Background section). In a study of 184 Burmese refugees, all reported "high symptom levels related to depression, anxiety, and posttraumatic stress disorder," but the risk for those who were also Karen and/or female was even higher (Kim, 2018, p. 179).

Beyond the aforementioned, limited research exists over the physical and mental health of Karen refugees (Hoffman & Robertson, 2016). It is therefore difficult to gauge how these individuals react to symptoms of mental illness or distress. The struggles of displacement and resettlement may lead some to react by turning to substances. A small body of literature exists over refugees and alcohol use disorder, which may occur among as many as a third of this population (Horyniak et al., 2016). Some turn to mental health providers, but traditional individual counseling may not adequately address their needs (Mitschke et al., 2017). Presently, there is not enough evidence to depict more clearly where and to whom these individuals turn in their time of mental health need.

Burmese Refugees' Mental Health Perceptions

Culture and language play a major part in how refugees perceive and act upon their mental health issues. World Relief Fort Worth (2014) reports that Karen often respond with 'yes' rather than 'no' to be polite, which can make assessments difficult to conduct. The Karen also view indirect eye contact as polite, unlike the American tendency to maintain eye contact while speaking (World Relief Fort Worth, 2014). Refugees from countries including Burma reported a number of reasons for not discussing mental health: "(a) history of political repression, (b) fear, (c) talking does not help, (d) lack of knowledge about mental health, (e)

avoidance of symptoms, (f) shame, and (g) culture" (Shannon, Wieling, Simmelink-McCleary, & Becher, 2015, p. 281).

Studies specific to how Burmese people view mental health have had inconsistent findings. A study by Fellmeth et al. (2015) interviewed 92 pregnant Burmese women living in camps on the Thai-Myanmar border about their perceptions of causes, manifestations, and effective treatments of mental illness. In general, the women were willing to discuss mental health openly, despite its attached stigma (Fellmeth et al., 2015). Some participants in a similar study of Karen women resettled in the U.S. were also vocal about their mental health concerns, but this was not unanimous (Power & Pratt, 2012). Despite the variation, depression was discussed more than any other topic in the study (which was not limited to mental health topics) followed by "housing, finances, paying bills, unemployment, and language barriers" (Power & Pratt, 2012, p. 164). Conversely, some Karen have described needs such as employment or transportation as more critical than mental health needs (Mitschke et al., 2017). One study found that when counseling was sought, Karen refugees reported receiving encouragement and help with employment, prioritizing needs, adjusting to the U.S., managing stress, and dealing with uncertainty; this same study, however, discussed how traditional one-on-one counseling may not suffice for refugees (Mitschke et al., 2017). It is clear that more research is necessary to address conglomerate findings and provide more clarity for researchers and practitioners alike.

Method

The purpose of this pilot study was to explore the perceptions of depression among resettled Karen refugees from Burma. Because little is known about how the Karen people understand mental health generally, and depression specifically, the results of this qualitative

exploratory study will be useful in guiding the development of depression screening and treatment efforts for this population.

In order to gain an initial understanding of how the Karen understand depression, participants were asked to explain what they think it means when someone is "depressed," if they themselves have ever felt depressed, and the best ways to help Karen people who are depressed. The researcher then probed for information related to these questions to attain a clear understanding of the participant's perceptions of depression. The survey included an additional question related to somatization (headaches, back pain, fatigue, etc.). A complete listing of all survey questions is included in Appendix C.

Participants

The target population for this study included Karen refugees ages 18 and older who receive medical care or case management through the Sunday Refugee Clinic held at the Agape Clinic in Dallas, TX. The Sunday Refugee Clinic is a volunteer-run medical and social service program that has been providing free and low-cost care to refugees from Burma on Sunday afternoons since 2012. While the Sunday Refugee Clinic serves people who are Karen, Burmese, Karenni, Chin, and Rohingya, in order to participate in the present study, participants had to be Karen.

A total of 16 participants were interviewed for this study. Thirteen of the 16 participants were female. The mean age was 36.18 years. It is worth noting that the U.S. State Department has commonly assigned a birth date of January 1 to refugees who do not know or cannot prove theirs or their children's; this means that many refugees may not know how old they actually are (Breidenbach, 2011). Participants reported spending, on average, 10.18 years in the U.S. and 11 years in camps. Table 1 displays the complete demographic characteristics of each participant.

Table 1. Demographic characteristics of participants

	Gender	Age	Years in US	Years in Camp
Participant 1	F	63	15	10
Participant 2	F	31	7	12
Participant 3	F	38	9	10
Participant 4	M	18	11	7
Participant 5	F	38	12	10
Participant 6	F	44	7	10
Participant 7	F	54	5	24
Participant 8	F	38	11	4
Participant 9	M	42	11	17
Participant 10	F	36	5.5	9
Participant 11	F	19	11	7
Participant 12	F	24	13	10
Participant 13	M	37	13	10
Participant 14	F	27	9.5	16
Participant 15	F	31	11	8
Participant 16	F	49	12	12

This pilot study involved the collection and analysis of a subset of the data collected for a larger depression screening study. The study was approved by the University of Texas at Arlington Institutional Review Board in June 2019.

Procedure

The researcher attended the Sunday Refugee Clinic on two consecutive Sunday afternoons, and, working with a trained interpreter, explained the purpose of the study and consent, and answered any questions from potential participants. The recruitment script, included in Appendix A, was verbally translated, and if an individual indicated a desire to participate in the study, the consent form (see Appendix B) was explained verbally and provided in written form in both English and Karen.

The researcher interviewed each participant in a private room to ensure confidentiality. Demographic and other study questions (see Appendix C) were asked verbally, with the researcher transcribing the participants' responses during the interview process. As anticipated, the data collection process lasted no longer than 15 minutes per participant.

Once the demographics information and screening interviews were complete, the information was stored in a password-protected file. Data collected on site was kept in a locked file box and transported back to UTA after each data collection session. The locked file box containing the data will never be out of the direct possession of the principal investigator and will be stored in a locked file cabinet in the principal investigator's locked office, room 313A in the School of Social Work. The files will be available for three years from the date of this study and then shredded.

The researcher conducted content analysis on each of the qualitative questions asked of participants and coded responses according to common elements across participants. From these codes, emergent themes were extracted in an attempt to address the research questions. Additional data and outliers are included in the results to provide a comprehensive analysis of all collected data.

Results

Participants' Descriptions of Depression

Five themes emerged from responses about what it means when someone is depressed. According to the first four themes, depression is when someone is experiencing 1) emotional distress, 2) cognitive impairment, 3) relationship conflicts, or 4) somatization. While these themes relate to what depression looks or feels like, the fifth theme discusses causes of

depression. Subthemes emerged within each of these major themes. Each will be described in detail with accompanying examples.

Experiencing emotional distress. According to many participants, depression means that someone undergoes a change in mood. Several described a depressed person as unhappy, and one described the desire to cry. A 27-year-old female respondent stated that when a person is depressed, "You can tell by looking at their face" because "they smile but it's not real." Another participant described having a "gloomy" affect. Among emotion-related responses, two subthemes emerged: anxiety and hopelessness.

Anxiety. For some, depression or unhappiness was related to worry about their children's health or futures. One mother mentioned that her children are sick, so she feels depressed. A 26-year-old female with two children stated that depression is related to "being fearful of rules and what can happen to us and our children." A quarter of the refugees described worrying about financial problems. Some related depression to troublesome family finances, and another specified that people become depressed when "they can't pay bills or for medical services like insurance."

Hopelessness. Four refugees described feeling unhappy, hopeless, helpless, or a combination of the three. A 63-year-old participant with previous experience with depression explained it as "For me, [the] heart and brain are tired." People who are depressed "suffer a lot and burn out," she continued. This emotional exhaustion and burning out also arose in one participant's mention of suicide as a potential symptom of depression. A 54-year-old refugee spoke at length about how her inability to hear, walk, or see well has caused her to feel sad and hopeless because she cannot help the family.

Experiencing cognitive impairment. The second major theme arose in half of all respondents' answers: a decline in cognitive functioning. For some, this impairment was demonstrated by difficulty thinking clearly or quickly. For others, the person's cognitive impairment was made obvious by his or her compromised speech patterns. In other words, the depressed person cannot think or speak as well as before. Two exceptions arose in this topic. One refugee suggested overthinking as a symptom and another as paranoia (thinking everyone is "out there to get them").

Thought disruptions. One form of cognitive impairment cited numerously was compromised thinking patterns. To some individuals, that meant the person could not organize his or her thoughts. One participant described depression as the brain "not working" as well as it used to. For other participants, the person's cognition suffered in the form of memory loss: he or she either lost track of what they needed to do or what they were currently attempting to do.

Communication. Several refugees described cognitive impairment as made evident by an inability to convey thoughts well or at an appropriate speed. Participants pointed to talking slowly, less often, or ceasing to talk. One stated that the "brain is not clear when they talk," directly referring to cognitive difficulties. Others brought up poor communication but in the context of familial discord, which will be discussed later.

Experiencing relationship difficulties. A third theme emerged with regard to relationships or interactions with others. For many, depression meant that relationships with others suffered, perhaps with romantic partners or in general. Most often, however, these difficulties occurred within the family. Relationship difficulties also arose as some form of social isolation, whether intentional or situational.

Family conflict. More than half of participants mentioned "family problems," but the phrase meant something slightly different to each of them. The most common type of family problem was misunderstandings or arguments, including one comment about the family's disinclination to work on those disagreements. One respondent said that the person no longer talks to the family when he or she is depressed. Other examples included discord caused by family finances, such as paying for bills or medical insurance. Lastly, a few mentioned the husband's behavior as the cause of depression, such as yelling or accusations of an extramarital affair.

Social isolation. The subtheme of social isolation came up in many forms. Responses spanned from behaviors such as staying alone, hiding in their room, or spending their daily life alone to having no one to talk to. Unintended social isolation occurred because of differences in culture. One refugee attributed his isolation to being unable to speak English while another ascribed her feelings of isolation to being a foreigner in the U.S.

Somatization. Physical manifestations of depression comprised the fourth theme. The majority of participants reported taking medication for commonly reported somatization issues, such as headaches, back pain, fatigue, or sleep problems. Others mentioned specific observable behaviors of depression, such as lethargy or sickliness. From these responses, several subthemes emerged: insomnia, fatigue, and health decline.

Sleep issues. Many refugees mentioned not being able to sleep as a symptom, and half of all participants reported taking medication to help them sleep. However, only a few associated not being able to sleep as a symptom of depression. It is worth noting that one of the few participants who connected insomnia with depression was not taking sleeping medication. In

fact, over half of those taking sleep medication did not mention sleep at all. One refugee mentioned sunken eyes, which could result from a lack of sleep.

Fatigue. Fatigue or general lethargy were mentioned frequently, sometimes more than once by the same participant. Refugees referred to moving slowly, lacking energy, feeling weak, and no longer doing the things you enjoy. Alternatively, one participant described inactivity as the *inability* to do what you enjoy, such as travel. In one way or another, the depressed person's actions evanesced.

Overall health decline. Physical illness was mentioned by a few. Responses included not looking well or not feeling well. One participant described physical illness as "not eating much" because of depression. The same refugee who spoke of her physical inabilities directly linked her depression with her health decline. She explained that after childbirth, she had to work long hours seated in a chair. She stated that this immobility led to her current physical disabilities, which in turn has led to her husband yelling at her and her children being ashamed of her.

Causal factors. Across many responses, a general trend arose: participants referring to causes of depression in their descriptions of depression. Even though most of these causal factors fall into other subthemes, they share the characteristic of not necessarily being symptoms of depression. These causal factors can be categorized as financial, family, or acculturative stress. As previously stated, family and money problems came up frequently, but they were typically in the context of reasons for the person's depression, rather than consequences of that person's depression. Needing a translator and dealing with completely new rules (e.g., driving rules, having house and water payments, so many fines) were forms of acculturative stress described as causes of depression.

Participants' Experiences with Depression

The majority of participants reported experiencing depression. Out of those who had, some reported a single experience that lasted a finite period of time, such as only during 2013 and 2014. A handful cited experiencing depression "sometimes," and the rest reported having ongoing depression. Almost every refugee with ongoing depression stated that she had been living with it for over a decade. Only one of the three male participants reported any history of depression, which was for a finite time period. Many refugees in this study stated that their depression followed a specific event, such as the loss of physical ability or a younger sibling.

Optimal Treatment Options for Karen People Who Are Depressed

When asked what the best way to help Karen people with depression is, participants offered solutions that fell into one of six themes. These themes involve emotional support, communication, practical solutions, coping skills, spirituality, and physical health. The most frequent response was to provide some type of encouragement or motivation. Other suggestions took a psychotherapeutic, practical, or spiritual approach.

Emotional support. The solution offered most often was to encourage the person experiencing depression. Some refugees specifically used the word "encourage" or "encouragement," while others more generally mentioned motivation. For some, that emotional support did not have to be verbally communicated. One refugee stated, "Be there for them" or "Show them attention." The overarching message was to provide emotive support to the person, whether through motivation, reassurance, or simply being present.

Increased communication. The second most common recommendation was for Karen people to talk about depression more openly among one another. These individuals indirectly referred to the stigma attached to depression that can lead people to avoid discussing it; only one

person openly acknowledged this stigma. Another person suggested that the person talk to his or her family and parents about his or her depression. This same individual inversely proposed that parents open the discussion with their children. Half of participants who gave this suggestion made sure to include listening to the person: "Ask someone if they're depressed and let them talk." Many recommended amplifying the discourse about depression by also increasing education and awareness. The same individual who advocated for parents to ask their kids also urged them to learn how to recognize symptoms.

Practical solutions. Problem-solving solutions were brought up by half of participants. This topic covered employment, finances, situational changes, and other everyday matters. Employment-related solutions included "If they work, they need the job that is not forced or hard but is flexible," or "they can work from home." A few financial suggestions were to help the person with bills and daily purchases or lending cash. Other practical solutions were to help around the house, to remove the person from the depression-causing situation, and to volunteer to take care of him or her. A few participants suggested prescribing antidepressants to help with depression.

Coping skills. Another frequent theme referred to what a mental health professional might call coping skills. These included pursuing hobbies, such as planting in the community garden, doing something that "makes them happy" or that "gets rid of depression and stress," and having an optimistic and positive mindset. A few individuals suggested turning toward places such as the Agape Clinic for its social services, perhaps every day rather than only on Sundays.

Spirituality. For some refugees, religion was the best way to help Karen people who are depressed. Nearly all participants reported attending church; one refugee who did not go to church explained that she desired to but was physically unable to be in crowds or sit for a long

time. Some promoted the use of prayer and going to church. One advised improving overall spiritual health. A few advocated for the person to learn about the Gospel and how Jesus "can help them with their problems."

Physical health improvements. Several individuals alluded to improving physical health. Some spoke of physical health in general while others directly advised improving certain health-related behaviors. For example, one refugee suggested for the person to make efforts to "eat healthy," and also "live healthy." A few others pointed to utilizing the Agape Clinic's medical services, such as medication administration and management.

Discussion

The Karen participants in this study perceived that depression was associated with experiencing emotional distress and spoke specifically about feelings of anxiety and hopelessness. This is consistent with research that has indicated that refugees experience high rates of co-occurring mental health disorders such as depression, post-traumatic stress symptoms, and anxiety (Briggs & Macleod, 2006; Kim, 2018). Participants also associated depression with cognitive impairment, such as thought disruptions and speech irregularities. This finding was unsurprising, since cognitive impairment is a central aspect of depression, particularly major depressive disorder (Douglas & Porter, 2009). Refugees in this study also mentioned relationship strain, particularly within the family. This finding is important to address since research suggests that strong family bonds may promote resilience and help combat stress (Hutchinson & Dorsett, 2012). Participants also mentioned social isolation, which Karen refugees already face because of their uncommon language and culture (John Tinpe as cited in Trieu & Vang, 2015).

This study also found somatization to be reported in relation to depression, specifically insomnia, fatigue, and physical health decline. Similarly, other researchers have found that Karen refugees tend to report somatization, sometimes more frequently than mental health symptoms (Hinton, Hinton, Eng, & Choung, 2012; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011; Shannon, Vinson, Wieling, Cook, & Letts, 2015). While sleep specifically has been referred to as "a hallmark…of post-traumatic stress disorder," sleep disturbances can also result from and worsen depression (Lommen et al., 2016; Sandahl, Jennum, Baandrup, Poschmann, & Carlsson, 2017, p. 6). This points to the benefits of psychoeducational programs that group PTSD, depression, anxiety, and sleep together (Sandahl et al., 2017).

Many participants discussed causal factors of depression rather than or in addition to depression symptoms. Common issues were related to financial, family, or acculturative stress. This strengthens previous findings about how post-migration stressors are significant contributors to mental health decline (Rasmussen, Crager, Baser, Chu, & Gany, 2012; Schweitzer et al., 2011). Despite the scarcity of literature on Karen refugees' mental health, even early studies indicated high levels of depression from post-migration struggles (Schweitzer et al., 2011). It was therefore unsurprising that several refugees reported that their depression worsened after resettling in the U.S.

Participants in this study most often suggested to help Karen people who are depressed with encouragement, which Karen refugees in other studies denoted as beneficial (Borwick, Schweitzer, Brough, Vromans, & Shakespeare-Finch, 2013; Mitschke et al., 2017). The refugees also recommended talking more about depression. It is worth noting that although many suggested helping Karen people by increasing levels of communication about depression, only one person directly referenced the stigma surrounding depression among Karen. This supports

findings that although mental health stigma may be a common barrier to treatment for refugees, some Karen may be exceptions (Fellmeth et al., 2015; Shannon, Wieling, McCleary, & Becher, 2015; Shannon, Wieling, Simmelink-McCleary, & Becher, 2015).

A number of respondents grouped talking more about depression with learning more about it. Psychoeducation with refugees may cover "symptoms of PTSD and depression; the rationale of treatment; physical activity, bodily reactions and anxiety; how PTSD affects the brain; sleep disturbances; healthy life style, including a proper diet and exercise; breathing and relaxation exercises, and chronic pain" (Nordbrandt, Carlsson, Lindberg, Sandahl, & Mortensen, 2015, p. 5). Topics over physical health could be especially beneficial, since it was another topic raised repeatedly in this study.

Other refugees advised providing practical solutions and utilizing psychotherapeutic tools, such as optimism and positive thinking. Problem-solving and therapeutic strategies have both demonstrated success in improving outcomes for refugees (Borwick et al., 2013; Schweitzer et al., 2011). Spirituality was another coping mechanism for several refugees. A number of findings have cited religiosity as a protective factor, coping mechanism, or matter of significance for refugee groups (Borwick et al., 2013; Rangkla, 2013; Yarris, Stasiun, Musigdilok, & Win, 2015).

One noticeable trend that occurred within refugees' answers was that some described depression in general while others described their personal experience with depression. This surfaced in very specific stories, such as one participant experiencing depression because her husband accused her of cheating, as compared to another refugee's response that encompassed physical health, spiritual health, employment, and coping skills. This specificity arose again in

responses for how to help Karen people who are depressed, most notably in the responses about female participants moving away from verbally abusive husbands.

Another commonality was that these refugees, as with many other cultures, spoke of depression as situational or reactionary rather than as a diagnosable illness related to biology or genetics (Alemi, Weller, Montgomery, & James, 2016). This was more evident in the question about refugees' personal experiences with being depressed. Many respondents gave specific time frames or reasons for their depression. One reported being depressed "when driving or if you can't help someone" and another since 2007 when she moved to the U.S. One refugee stated that she had been depressed for 17 years, beginning when she first became disabled. Only one refugee came close to describing her depression as a long-term illness that has stayed with her almost her entire life. She stated that she had been depressed since she was small but did not realize it until she was 13, when her youngest sister died, her family was sick, her father was on duty, and they had to "run from the enemy" into the deep recesses of the jungle. She stated that it has only gotten worse since she relocated to the U.S.

Implications

One can infer from responses about helping Karen people that treatment may be more effective if communal, educational, and perhaps religious aspects are incorporated. Promoting a sense of solidarity may also be of significance, as reflected in refugees' efforts to encourage and help one another with their problems. For this group of refugees, help took many forms, such as practical help with daily stressors or emotional support with words of encouragement. Mitschke et al. (2017) and Stewart et al. (2012) had similar findings about refugees reporting better outcomes after turning to one another for support and community.

Based on the low number of responses about depression as a health issue, there needs to be more education and awareness efforts among refugee populations. Increased knowledge about depression may lead refugees to seek the most appropriate evidence-based treatments for depression, such as a combination of psychotherapy and medication (Mayo Clinic, 2018; Nordbrandt et al., 2015). This does not mean that their personal and cultural values should be dismissed; conversely, the best treatment for this population may be medication along with some form of group psychotherapy.

These findings, and others related to refugee populations, may change the landscape of clinical social work education. The political and social climates of countries around the world are constantly changing, suggesting that there may be even greater influxes of refugees in the next couple of decades. Current and future social workers could benefit from a greater awareness of how to help such diverse populations. Soon it may be time to go beyond teaching cultural competence skills and begin sharing knowledge about the kinds of cultures that new social workers may encounter. These cultures may rely heavily on one another for support and may want to solve more concrete problems before addressing mental health concerns. Karen refugees are one such population. Even though the number of refugees allowed into the U.S. is decreasing, those resettled here are still in need of help with understanding, navigating, and adjusting to American life (Krogstad & Gonzalez-Barrera, 2019; Silove et al., 2017).

Conclusion

Even after refugees manage to escape persecution, they still carry past traumas and issues with them while facing new, foreign ones. Karen refugees start at a further disadvantage because of persecution and cultural differences. There is a slowly growing body of research about how to help this population, but there is still more progress to make. This study of Karen refugees'

perceptions of depression revealed that this group tends to view depression as experiencing emotional distress, cognitive impairment, and relationship difficulties. Their suggested recommendations include providing emotional support, or practical solutions, increasing communication and awareness about depression, improving coping skills and health, turning to spirituality, or a combination of these. The overarching commonalities appeared to involve social, problem-solving, or religious aspects. These findings offer suggestions for future practice, research, and social work education. Future studies may examine what specific kinds of encouragement are most beneficial for this group or how these findings compare for other refugee populations. Ultimately, any work conducted with Karen and other refugee populations must strive to respect and adhere to the population's specific culture, preferences, and most appropriate interventions.

APPENDIX A

RECRUITMENT SCRIPT

We would like to know if you would like to participate in an interview for a research study. Would you like to hear more about what would be asking?

No: Okay, no problem.

Yes: Okay. We would like to ask you some questions about feelings of sadness, your experiences coming to the US and about your relationships. The interview should take about 15 minutes. You do not have to answer any questions if you do not want to. We are not going to share any of your personal information with anyone else.

If you think you would like to participate in the interview, we will explain more about the study. If you understand and agree, we will ask you to sign a form. The form says you understand the purpose of the study and that we have answered any questions you have.

Are you interested in learning more about the study now?

No: Okay, no problem. If you decide you are interested later, please contact me (Diane Mitschke) here at the Agape Clinic. I am here every Sunday afternoon from 2:30-5:30.

Yes: Ok, let us go over the consent form together.

APPENDIX B

CONSENT FORM IN ENGLISH

Informed Consent

Title of the Study: Depression screening of resettled Karen refugees in a community-based clinic

Principal Investigator: Diane Mitschke, PhD

Introduction: We are asking you to be a part of this study so, we can learn more about your feelings of sadness, your experiences coming to the US and about your relationships.

Description of Procedures:

1. You must be 18 years of age or older to participate in this study.
2. If you want to be in this study, you must sign a form that says you agree.
3. You will be asked questions that will take no more than 20 minutes.
4. You can skip a question, not answer a question, or stop at any time.
5. It is your choice to participate in this study. You do not have to participate if you do not want to participate.

Risks: You may feel sad answering questions about your feelings or relationship. If you feel this way, you are welcome to stop answering questions. If you want to stop, there will not be a problem. You can also ask for help at the clinic if you feel sad.

Benefits: You will help us learn more about how to care for Karen refugees who are feeling sad.

Compensation: You will not get anything for being in the study and answering the questions.

Cost: It is free to participate in this study. It does not cost money.

Confidentiality: Everything you share with us will be kept private unless you say that someone is hurting a child, an elderly person, or a person with a disability and we have to tell the proper authorities. Even though the results of this research study may be used in reports, presentations, and publications, we will not give your name to anyone. More research might come from this study, but your information will not be connected to your name in any way. A copy of the signed form, and any other forms we ask you to fill out will be kept in Diane Mitschke's office in the UTA School of Social Work in a locked cabinet for 3 years. After three years, these files will be deleted. No one will see these forms except the people on the research team. Although your rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the UTA Institutional Review Board (IRB), and personnel to this research have access to the study records. Your records will be kept completely confidential per current legal requirements. They will not be shared unless required by law. The IRB at UTA has reviewed and this study and the information within this consent form. If in the unlikely event it becomes necessary for the Institutional Review Board to review your research records, the University of Texas at Arlington will protect the confidentiality of those records to the extent permitted by law.

Questions: For more information about the study ask Diane Mitschke at the clinic or call her at (817) 807-1464. If you need an interpreter, call Paw Mwee at (436) 364-0030. If you have any questions about the rights of research subjects or research-related injury, please contact the IRB Administrator, Alyson Stearns at 817-272-1173 or asterns@uta.edu. Office for Responsible Research, University of Texas at Arlington.
Signature: If you sign, this means that indicates that you want to participate, that you are old enough to be participate, that someone has read and explained this document to you, and that your questions have been answered.
Participant's Name: (Printed) _____
Participant's Signature: _____ Date: _____

As a representative of this study, I have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study:

Signature of principal investigator attaining consent: _____

Date: _____

APPENDIX C

DEMOGRAPHIC AND SCREENING TOOL

Demographics

1. What is your birthdate?_____
2. In which country were you born?
    a. Burma
    b. Thailand
    c. Other_____
3. How many years have you lived in the U.S.?
4. How long did you stay in the refugee camp before you came to the U.S.?
5. Are you male or female? _____
6. Who lives with you in your home?
7. Do you have family in Dallas?
    a. Yes
    b. No
8. Do you have other family members back home?
    a. Yes, if yes who?_____
    b. No
9. How often do you have a drink containing alcohol?
        (0) Never
        (1) Monthly or less
        (2) 2 to 4 times a month
        (3) 2 to 3 times a week
        (4) 4 or more times a week
10. How well do you understand English?
    a. Not at all
    b. A little
    c. Some
    d. Very well
11. How well do you speak English?
    a. Not at all
    b. A little
    c. Some
    d. Very well
12. How well do you read English?
    a. Not at all
    b. A little

c. Some
d. Very well

13. Do you have a job?
    a. Yes
    b. No
14. What is your job?_____
15. How many hours a week do you work ? _____
16. Do you go to church?
    a. Yes
    b. No
17. How important is church to you?
    i. Not at all important
    ii. A little
    iii. Somewhat important
    iv. Important
    v. Very important
18. Do you take medications for any of the following?
    a. Headaches
    b. Back pain
    c. Feeling tired
    d. Because you can't sleep
19. What is the name of the medication? _____
20. What do you think it means when someone is "depressed"?
21. Have you ever felt depressed?
22. What is the best way to help Karen people who are depressed?

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