The influences of basic needs, social support and migration on mental health in South Sudan

Alison Schafer
(Student I.D. 1815040)

Supervisors:
Associate Professor Christine Critchley
Professor Glen Bates

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Swinburne University of Technology

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Table of Contents

Tables ..................................................................................................................................... viii
Figures ....................................................................................................................................... xi
Declaration ............................................................................................................................. xiii
Acknowledgements ................................................................................................................. xiv
Abstract ................................................................................................................................... xvi

CHAPTER 1: RESEARCH INTRODUCTION ........................................................................ 1
  1.1 Overview of research .................................................................................................. 1
  1.2 Overview of mental health issues in developing countries ........................................ 4
  1.3 Overview of poverty ................................................................................................... 7
  1.4 Overview of the links between basic needs, social support and migration on mental
      health .............................................................................................................................. 8
  1.5 Overview of mental health and the cultural perceptions of mental illness.............. 11
  1.6 The South Sudan context ........................................................................................ 13

CHAPTER 2: ASPECTS OF MENTAL HEALTH IN DEVELOPING CONTEXTS ........... 25
  2.1 Defining mental health ............................................................................................. 25
  2.2 Cultural measurement and perceptions of mental health/mental illness .............. 26
  2.3 The experience of displacement and forced migration ............................................. 32
  2.4 The stress of acculturation and adaptation among refugees living in developed
      countries .......................................................................................................................... 35
  2.5 Refugee psychopathology ........................................................................................ 40
  2.6 Implications of cultural perceptions of mental illness for diagnosis and research in
      developing contexts ......................................................................................................... 49
      2.6.1 Common mental illnesses and their symptoms ............................................ 54
4.3.7 Hopkins Symptom Checklist-25 (HSCL-25) ......................................................... 125
4.3.8 Measuring metal health ...................................................................................... 128
4.3.9 Qualitative methodology .................................................................................. 129
4.4 Summary of methodology .................................................................................... 130

CHAPTER 5: FIRST STUDY RESULTS - ANALYSIS OF INFLUENCES ON MENTAL
HEALTH IN SOUTH SUDAN ............................................................................................ 132

5.1 Preliminary quantitative exploratory analysis ....................................................... 133
  5.1.1 The influence of gender on basic needs, social support, acculturative stress
       and mental health .................................................................................................. 133
  5.1.2 The influence of age on basic needs, social support, acculturative stress and
       mental health ........................................................................................................ 137
  5.1.3 The influence of education attained on social support, acculturative stress
       and mental health .................................................................................................. 139
  5.1.4 The influence of marital status on basic needs, social support, acculturative
       stress and mental health ....................................................................................... 142
  5.1.5 The influence of employment status on basic needs, social support,
       acculturative stress and mental health .................................................................. 143
  5.1.6 Summary and post hoc analyses of preliminary quantitative findings .......... 147

5.2 Hypothesis 1 results ............................................................................................. 150

5.3 Hypothesis 2 results ............................................................................................. 157
  5.3.1 Additional exploration of the returnee group ................................................... 163
  5.3.2 Post hoc analyses and potential problems with the acculturative stress
       measure .................................................................................................................. 165

5.4 Study 1 summary of quantitative analysis ............................................................ 168
CHAPTER 6: SECOND STUDY RESULTS - IMPRESSIONS OF MENTAL ILLNESS IN SOUTH SUDAN

6.1 Research questions ......................................................................................... 172

6.2 Method ................................................................................................................ 173
   6.2.1 Participants ................................................................................................. 173
   6.2.2 Semi-structured interview questions .......................................................... 173

6.3 Qualitative data treatment....................................................................................... 179

6.4 Researcher disclosure: Personal reflections on mental health in humanitarian contexts ......................................................................................................................... 181

6.5 Results from the analyses of the subjective impressions of mental illness in South Sudan ......................................................................................................................................................................................... 185
   6.5.1 Social structure for participants in their community................................. 186
   6.5.2 Participant perceptions and feelings about community problems ............. 189
      6.5.2a Main problems in the community.......................................................... 190
      6.5.2b Feelings about present situation ..................................................... 192
   6.5.3 Participant perceptions regarding mental illness ....................................... 194
      6.5.3a Signs of emotional or mental health problems ............................... 196
      6.5.3b Names for people with emotional or mental health problems ........ 199
      6.5.3c Causes of mental illness .................................................................. 202
      6.5.3d Treatment for mental illness ........................................................... 206
   6.5.4 Community responses to people with mental illness ................................. 209
   6.5.5 Perceptions of control and views of the future ....................................... 212
      6.5.5a Autonomic control .......................................................................... 213
      6.5.5b Views of the future in 2 years ......................................................... 215
      6.5.5c Views of the future in 10 years ....................................................... 218
6.5.6 Observations and additional comments ..................................................... 219
6.5.7 Key informant interview ............................................................................ 222
6.6 Summary of the qualitative analysis................................................................. 232

CHAPTER 7: DISCUSSION......................................................................................... 236
7.1 Summary of results in relation to research hypotheses and questions ........... 237
  7.1.1 Summary of the preliminary analysis from demographic data................. 237
  7.1.2 Summary of quantitative analysis from Study 1 in relation to hypotheses 239
  7.1.3 Summary of qualitative analysis from Study 2 in relation to research questions................................................................. 240
  7.1.4 Integrated summary of key research findings ............................................ 245
7.2 Methodological challenges of the research ....................................................... 248
  7.2.1 Sampling issues .................................................................................. 250
  7.2.2 Quantitative measurement issues ........................................................... 250
  7.2.3 Qualitative methodological challenges .................................................. 255
7.3 Theoretical implications of the findings........................................................... 258
  7.3.1 South Sudan’s context........................................................................ 258
  7.3.2 Basic needs, safety and social inclusion for mental health and wellbeing 260
  7.3.3 Understanding the construct of social support in South Sudan ............ 263
  7.3.4 The returnee experience ...................................................................... 265
  7.3.5 Southern Sudanese perceptions of mental health..................................... 268
  7.3.6 Southern Sudanese perceptions of mental health – a dichotomous or dimensional perspective? .......................................................... 269
  7.3.7 Psychopathology and the DSM-IV-TR Cultural Formulation............... 271
  7.3.8 Perceptions of control and views of the future ..................................... 273
7.4 Practical implications of the findings............................................................... 274
7.4.1 Practice implications for mental health research across cultures........... 275
7.4.2 Practice implications for psychologists working in developing contexts.. 277
7.4.3 Practice implications for humanitarian organisations responding to mental health needs in post-conflict and developing contexts............................. 279
    7.4.3a Returnee mental health care......................................................... 285
    7.4.3b Gender considerations in mental health care............................... 286
7.5 Further research for mental health care in post-conflict and developing contexts 288
7.6 Conclusion............................................................................................................. 292
REFERENCES...................................................................................................................... 293
Appendix A: Map of the Republic of the Sudan and The Republic of South Sudan ....... 316
Appendix B: Research Interview Schedule ................................................................. 317
Appendix C: Signed Translator Confidentiality Agreement ........................................... 327
Appendix D: Research Participant Verbal Consent Form .............................................. 328
Appendix E: Symbol cues used with participants for the administration of the Perceived Social Support Scales for Family and Friends (Prociando & Heller, 1983) and the Catwe Acculturative Stress Scale (Berry et al., 1997) ................................................................. 331
Appendix F - Picture cues used with participants for the administration of the Harvard Trauma Questionnaire (Mollica et al., 2004) and the Hopkins Symptom Checklist-25 (Mollica et al., 2004) .............................................................................................................. 332
Appendix G: Samples of Prompting and Clarifying Questions used during Qualitative Research ................................................................................................................................. 333
Appendix H: Letter of Attestation outlining the Procedure and Declaration of the Independent Auditor of the Qualitative Research Themes ........................................................................... 335
Appendix I: Letter of Support for Research from World Vision South Sudan Programs Director .................................................................................................................................. 337
Appendix J: Letter of Support for Research from the South Sudan Relief & Rehabilitation Commission (SSRCC) – Upper Nile State Headquarters

Tables

Table 1  Marital status of participant’s in the host and returnee groups  85
Table 2  Percentage of completed education levels of total sample by gender and by group  89
Table 3  Frequencies of basic needs variables and total scores  100
Table 4  Spearman’s Rho correlations across basic needs variables and the Basic Needs Total Scores  103
Table 5  Summary of chi-square test for independence between basic needs variables and gender  104
Table 6  Summary of chi-square test for independence between basic needs variables and group (host and returnee groups)  105
Table 7  Reliability analysis for Perceived Social Support from Family subscale  110
Table 8  Reliability analysis for Perceived Social Support from Friends subscale  114
Table 9  Descriptive statistics for Perceived Social Support Family and Friends Subscales and the Perceived Social Support Total scores  117
Table 10  Reliability analysis for Acculturative Stress Scale  120
Table 11  Descriptive statistics for Acculturative Stress Somatic and Psychological Symptoms subscales and the total score for the Acculturative Stress Scale  121
Table 12  Descriptive statistics for Harvard Trauma Questionnaire (HTQ) for Posttraumatic Stress Disorder (PTSD) Symptoms, Other Impairment Symptoms and the Total Scores for the HTQ  125

Table 13  Descriptive statistics for Hopkins Symptom Checklist-25: Depression and Anxiety subscales and Total Scores  128

Table 14  Frequencies of Completed Education Levels by Gender  134

Table 15  Descriptive Statistics and Normality Tests by Gender for Dependent Variables  135

Table 16  Univariate Results for Basic Needs, Social Support, Acculturative Stress and Mental Health by Gender  136

Table 17  Descriptive Statistics and Pearson’s Correlations of the Research Variables and Age  138

Table 18  Correlation Analysis of Educational Attainment and Perceived Social Support, Acculturative Stress and Mental Health  141

Table 19  Marital status of participants in the total sample group by gender  142

Table 20  Pearson’s Correlations Between Steady Employment and Access to Basic Needs, Social Support, Acculturative Stress and Mental Health  144

Table 21  Descriptive Statistics and t-tests by Employment Status for Basic Needs, Acculturative Stress, HTQ and HSCL-25 Subscales and Total Scores  146
Table 22  Pearson’s Correlations Showing Relationships Between Gender, Educational Attainment, Employment Status and Acculturative Stress and Mental Health Total Scores  148

Table 23  Regression Analysis Showing the Unique Contributions of Gender, Education and Employment Status on Acculturative Stress, HTQ and HSCL-25 Total Scores  150

Table 24  Descriptive Statistics and Pearson’s Correlations for Basic Needs, Social Support, Acculturative Stress and Mental Health  152

Table 25  Hierarchical Multiple Regression Standardised Results for Basic Needs and Acculturative Stress Predicting Mental Wellbeing  156

Table 26  Descriptive Means and Independent Samples t-tests by Host and Returnee Group  158

Table 27  Summary of Tests of Moderation based on Host/Returnee Status  161

Table 28  Interaction Co-efficient Tests of Moderation by Host/Returnee Groups  162

Table 29  Pearson’s Correlations Between the Acculturative Stress Subscales and Total Scores and the HTQ and HSCL-25 Subscales and Total Scores  166

Table 30  Qualitative research questions and their Association with Questions asked in the Semi-Structured Interviews  174

Table 31  Interview questions developed for the qualitative research, based on the DSM-IV-TR (APA, 2000) Cultural Formulation categories  178
Table 32 Research question 1: Summary of emergent themes and their relationship with the qualitative research questions  186

Table 33 Research question 2: Summary of emergent themes about community problems, feelings about the present situation and names for people with emotional or mental health problems  189

Table 34 Research question 3: Summary of emergent themes about community perceptions regarding mental illness  196

Table 35 Research questions 4 and 5: Summary of themes related to feelings of control and views of the future  212

Figures

Figure 1 Acculturation attitudes of immigrant groups and larger society (Phinney, Berry, Vedder & Liebkind, 2006, p.74)  36

Figure 2 A mediation model of daily stressors as partially mediating the relationship between conflict and mental health (Miller & Rasmussen, 2010)  47

Figure 3 Depiction of Maslow’s Hierarchy of Needs and Motivation Model (adapted from Chapman, A., 2001)  60

Figure 4 Intervention pyramid for mental health and psychosocial support in emergencies (IASC, 2007, p.12)  62

Figure 5 The links and cycles of poverty and mental illness, adapted from World Health Organization (2001)  66

Figure 6 Outline of research format  76
Figure 7  Hypothesis of the relationship between basic needs, perceived social support and acculturative stress and mental health; and the order of the expected strengths of each variable  77

Figure 8  Expected outcome for the total sample group that the relationship of higher social support and higher mental health outcomes would be mediated by greater access to basic needs  78

Figure 9  Hypothesis for the strength of the influences of basic needs, social support and acculturative stress on mental health, moderated by host or returnee status  79

Figure 10  Distribution of Basic Needs Total Scores  99

Figure 11  Example of how data from the current research could be used to design a mental health program in South Sudan based on the Intervention Pyramid of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007)  283
Declaration

I declare that this report does not incorporate without acknowledgement any material previously submitted for a degree in any University, College of Advanced Education, or any other educational institution, and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

I further declare that the ethical principles and procedures specified in the Faculty of Life and Social Sciences Human Research Ethics Committee document have been adhered to in the preparation of this report.

Name: ______________________________

Signed: ______________________________
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“But in this new century, millions of people in the world’s poorest countries remain imprisoned, enslaved, and in chains. They are trapped in the prison of poverty. It is time to set them free. Like slavery and apartheid, poverty is not natural. It is man-made and it can be overcome and eradicated by the actions of human beings. And overcoming poverty is not a gesture of charity. It is an act of justice. It is the protection of a fundamental human right, the right to dignity and a decent life. While poverty persists, there is no true freedom.”

Nelson Mandela

Speech at a Make Poverty History rally in Trafalgar Square, London, 3 February 2005
Abstract

This research examined mental health and wellbeing in Africa’s newest nation, The Republic of South Sudan, and explored how poverty conditions, social support and returnee migration influenced peoples’ mental health. The thesis comprised two studies. The first study was a quantitative analysis followed by qualitative analysis as the second study. Both studies explored mental health and wellbeing with people who had remained in South Sudan throughout the 22 year civil war (“host”; n=26) and those who had been displaced but recently returned to their homeland (“returnees”; n=27). The first study determined that having access to basic needs was associated with lower scores on acculturative stress, posttraumatic stress, depression and anxiety. Women presented with lower mental health than men, but no differences were found in the mental health of host and returnee groups. The qualitative analysis of study two indicated that access to basic needs was the greatest concern for participants, with little mention of traumatic experiences influencing their perceptions of mental illness, its symptoms or causes. Social support was also established as a vital element to wellbeing, but preoccupation with poverty was shown to prevent many people, particularly women, from envisioning a hopeful future. Methodological limitations of the studies, including sampling, quantitative measures and translation challenges, which are common to cross-cultural research, were considered alongside the implications of the findings. Such implications included support for Maslow’s (1954) long-standing model of human motivation, the Inter-Agency Standing Committee (IASC, 2007) Guidelines for Mental Health and Psychosocial Support in Emergency Settings and theories that suggest daily stressors may be mediating the relationship between war exposure and mental health. Results are discussed in relation to psychological practice in developing countries, humanitarian responses to mental health needs in post-conflict settings and future research.
CHAPTER 1: RESEARCH INTRODUCTION

1.1 Overview of research

This thesis sought to contribute towards bridging the deficit in mental health research on developing countries by focusing on one of Africa’s poorest and most challenging contexts; a post-conflict region of South Sudan. The research comprised two studies: quantitative and qualitative analyses that each examined the influences of basic needs, social support and migration on mental health and wellbeing among two groups. The two groups included people who remained in South Sudan during wartime, henceforth referred to as the “host” group, and those who had lived in asylum during wartime but had recently returned to their homeland referred to as the “returnee” group. The qualitative study further explored Southern Sudanese perceptions of mental illness, how wellbeing linked to their poverty and post-war context, and how people in South Sudan viewed their futures in light of the issues they have and continue to face.

The need for mental health research in Africa and other low and middle income countries is imperative. Population statistics indicate that 80% of the world’s inhabitants live outside so-called “developed nations” and in places where the income differentials between rich and poor are widening (United Nations Development Program [UNDP], 2007). Despite this, Saxena, Guillermo, Pratap, Ghassan and Ritu (2006) reported that only 10% of health literature, including mental health publications, is dedicated to low and middle-income countries, also known as developing countries. In an attempt to bridge the gap in knowledge about mental health in developing nations, the World Health Organisation ([WHO], 2004), and other global mental health actors, such as the Office for Research on Disparities and Global Mental Health (Collins et al., 2011) have targeted the mental health needs of people living in and coming from developing nations as a priority.
This introductory chapter begins with a broad overview and exploration of key themes and terms relevant to the research. This includes the growing mental health issues in developing country contexts and the reasons Africa is considered vulnerable to growing mental health problems. There is also a brief analysis about how the focus on trauma and war, and the lack of reflections about cultural derivatives of mental illness have contributed to poor understanding of mental illness in developing countries and the critical and inseparable links between poverty and mental illness. Following this a justification for studying migration in developing countries given that most of the world’s displaced populations still live in non-western nations. Common terms used throughout the study are also outlined, such as the concepts of poverty, basic needs, social support, migration, acculturation and mental health.

The literature review includes a description of the unique South Sudan context, and socio-political factors that have contributed to poverty throughout the nation. Culture is covered and the role of women in South Sudan is explored. With this context and culture of South Sudan overarching the remainder of the literature review, other issues related to mental health in developing countries are discussed; including the paradigm of mental health and mental illness, the typical experiences of people who have experienced displacement or forced migration and the acculturative difficulties they face when adapting to a new country and culture. This expands to consider the idea that Southern Sudanese people who sought asylum in other countries during the war may be experiencing acculturative stress upon their return to South Sudan. Research on refugee psychopathology in both developed and developing contexts is then examined. This is followed by a review of the challenges of conducting mental health research in non-western cultures, which justifies the exploratory nature of the current research design and the utilisation of dual-study quantitative and qualitative mixed methods approach.
The literature review proceeds to verify some of the most common global mental illnesses and explains why the present study hones in on symptoms of depression, anxiety and trauma symptoms as measures of ill-health. However, the links between mental health/illness and poverty are not neglected. The research examines the most basic of survival needs, termed “Basic Needs”, and its foundations in International Human Rights Laws, Maslow’s (1954) psychological theory for the renowned Hierarchy of Needs model, and as the grounding principles of the Interagency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007), which offers a framework for the provision of mental health and psychosocial support in humanitarian work. The undeniable link between basic needs and wellbeing justifies the current study using a measure of basic needs as variable predictor of mental illness. Another predictor is “Social Support”. Western assessments of social support indicate its correlation with mental health and wellbeing, and from the South Sudan cultural perspective, social support may be a capital asset to people who require social connections for both support and survival.

The research questions were analysed using a quantitative and qualitative mixed methods design, comprising two concurrent studies. The first study was deductive and used quantitative measures. The first hypothesis of the first study considered the total sample group (host plus returnees) and expected that greater access to basic needs, social support and low acculturative stress would be associated with higher mental health outcomes and that of these influences, having adequate basic needs would be the highest predictor of mental health. It was further hypothesised that basic needs would mediate the relationship between social support and mental health. That is, the level of social support would lead to greater access to basic needs, which would in turn increase mental health. The second hypothesis of the first study examined the differences between the host and returnee groups and expected the host group to show greater mental health outcomes than their returnee counterparts and
that host or returnee status would moderate the influences of basic needs, social support and acculturative stress on mental health.

The second qualitative study used ethnographic questions about mental health and illness and the Diagnostic and Statistical Manual, Fourth Edition, Technical Revision (DSM-IV-TR) Cultural Formulation (American Psychiatric Association [APA], 2000) to inductively ascertain the research participants’ cultural and tribal affiliations, the problems they perceived in their communities and how this related to their mental health. Projective perceptions about their wellbeing were also examined through questions that asked participants about their feelings of control in their present situation and their views about the future. Specific hypotheses were not formulated but relationships were expected between basic needs, social support and mental health.

The Method chapter of the research provides an overview of the total sample group, including some of the key demographic differences between the host and returnee groups. The procedures for data collection are summarised, including a description of the interview schedule where both the quantitative and qualitative data was collected at the same time. From this point forward, the chapters divide the two concurrent studies. The first study presents analyses of the quantitative measures. The second qualitative study details the qualitative measures and presents the thematic analysis. An interpretation of the results from both studies is provided in the final discussion chapters.

1.2 Overview of mental health issues in developing countries

International epidemiological research estimates that mental and behavioural disorders account for 12% of the global burden of disease; however, there is increasing recognition that these figures are likely to be a gross underestimation due to the lack of data from developing countries (Kohn, Saxena, Levav & Saraceno, 2004; Schafer, Morgan &
Rabinowitz, 2009). There is extensive speculation surrounding worldwide rises in mental illness in both developed and developing nations. Theories to explain the increases in mental illness range from expanded psychiatric diagnostic categories (Baughman, 2008); improved healthcare alongside extended mortality rates (Boyd, 2006); the influences of psychopharmacological treatments (Whitaker, 2005); and ideas about developed nations changing their social interactions in the technological age and thus altering the quality of social relationships amongst peers and families (Szwedo, Mikami & Allen, 2011). In developing countries there is evidence that expected increases in mental illness may also be the outcome of greater urbanisation, as identified by Havenaar, Geerlings, Vivian, Collinson & Robertson (2008) for people living in South Africa.

Regardless of beliefs about why mental and behavioural disorders are on the rise, it is well-established that certain groups are particularly vulnerable to mental illness. This includes people living in adverse circumstances with minimal access to physical, social and financial resources, such as women (especially abused women), people living in extreme poverty, migrants and displaced persons, children and adolescents with disrupted nurturing and indigenous populations (WHO, 2003). Mental illness is therefore expected to increase in developing countries as child mortality rates decrease, and health services begin to consider wellbeing beyond physical health and mass population movements. Developing countries with ongoing pervasive poverty, malnutrition, increasing drug and alcohol abuse, conflict and lack of basic needs such as water, shelter, food and health services are predicted to experience greater mental health needs in the coming years (Abrahams, Jewkes, Hoffman & Laubesher, 2004; WHO, 2004). Specifically, Dyregrov, Gupta, Gjestad & Mukahneli (2000) argue that people living in Africa are at the highest risk of mental illness, given the continent’s persistent civil and tribal wars, population growth and migration patterns, human rights abuses and insidious poverty.
In the past 20 years alone, some of the world’s most brutal wars have ensued in Africa. Some key examples include the Sierra Leone and Liberia uprisings, Rwanda genocide, Ethiopia-Eritrea border conflicts, Lord’s Resistance Army conflict in northern Uganda, Eastern Democratic Republic of Congo and the major north-South Sudan\(^1\) conflict which was historically marked as Africa’s longest civil war (Johnson, 2011). Yet, regardless of the extraordinary humanitarian needs in Africa, it remains one of the world’s least researched regions in terms of mental health. This thesis aims to contribute to understanding mental health and wellbeing in a developing country; albeit in one region of The Republic of South Sudan (henceforth referred to as South Sudan) and Africa. It considers the impacts of poverty, social support and migration on the wellbeing of this conflict-affected community.

Summerfield (1999) suggested that one reason for the poor understanding of mental health in developing countries, compared with western nations, is an over focus on trauma and too little focus on the physical and cultural environments in which people live. Summerfield (1995) has long proposed that traumatic experiences of war are likely to only partially explain the causes of mental health problems when other variables, such as stressful living conditions and cultural perceptions, are likely to also contribute to mental illness. Similarly, Weiss, Saraceno, Saxena and van Ommeren (2003) submitted that an unbalanced and simplistic approach that limits research to the traumatic impacts of war on mental health cannot adequately address the broader and more holistic contexts of poverty and need in which most African people live. Further to this, Kleinman (1977; Kleinman & Cohen, 1997) and Thakker and Ward (1998) have long debated the relevance of a supposed universal taxonomy of mental illness that does not account for local perceptions of mental health,

\(^1\) Since the January 2011 succession of The Republic of South Sudan (short name: South Sudan) from the Republic of the Sudan (short name: Sudan), the international community formally recognises South Sudan and Sudan as two individual nation states. For ease of reading, this research commonly refers to “north Sudan” to distinguish it from South Sudan; however north Sudan is referred in lower-case ‘north’ to indicate that this is not the formal short name of the Republic of the Sudan.
illness and the macro contexts such as people living without basic needs. In all, prior mental health research in Africa over-emphasises trauma and underestimates the influences of context and culture in relation to mental health and illness, and this has largely contributed to a poor understanding of mental health concerns in developing countries, including Africa (Ingleby, 2005).

1.3 Overview of poverty

In 2010, the World Bank estimated that approximately 3 billion people across the globe lived on less than US$2 per day while an estimated 1.4 billion people live on less than US$1.25 per day and are considered to be living in ‘extreme poverty’. The factors that comprise poverty are complex, however, and consist of influences beyond facts and figures. Mading Deng (2003) highlighted that poverty is both objective and subjective. From an objective perspective, internationally-recognised indicators of poverty include measures of individual gross incomes (including access to dollars-per-day), access to health care, primary education levels of a population and child-mortality rates. Yet, Mading Deng points out that many culturally subjective indicators can also ascertain whether or not individuals or families are rich or poor within their own communities. In South Sudan for instance, the Dinka tribe perceives that the male heads of families who possess large herds of cattle would be considered wealthy, even though the internationally-recognised objective indicators view them as living a life of poverty. Sachs (2005) takes an alternative view of poverty, which may be more useful in defining poverty and how it can be differentiated between moderate, relative and extreme poverty. Sachs defines extreme poverty as: “households [that] cannot meet basic needs for survival. They are chronically hungry, unable to access health care, lack the amenities of safe drinking water and sanitation, cannot afford education for some or all of the children, and perhaps lack rudimentary shelter” (p.20).
Although poverty is a multifaceted construct and a technical analysis of that construct sits outside the scope of this project, poverty is generally viewed, in its simplest terms, as people lacking their basic needs. For the purposes of this dissertation, poverty refers to people lacking their basic survival needs such as water, food, safety and shelter, as suggested by Sachs (2005). This research speaks broadly about the poor, poverty and its connection to people living without their basic needs. The research acknowledges the complexity of poverty, however, it hones in on basic needs as the measurable variable to analyse its potential influence on mental health and wellbeing in the developing context of South Sudan.

1.4 Overview of the links between basic needs, social support and migration on mental health

Recently, international consensus has emerged on the need to explore mental health in developing contexts in a way that not only considers the impact of trauma and responses to traumatic events such as war, but also the underlying links between poverty and mental illness (van Ommeren, Saxena & Saraceno, 2005; WHO, 2001). Longstanding theories, such as that of Maslow’s Hierarchy of Needs (Maslow, 1971) are being revisited in working toward approaches that ensure physiological safety and security needs are a foundation for people to maintain social support and ultimately, psychological wellbeing.

Over the years, research in developed countries has revealed that family and social support are significant protectors for people at risk of mental illness (e.g., Friborg, Hjemdal, Rosenvinge & Martinussen, 2003; Hobfoll, 1998). This is based on the notion that social support is a way for people to attain physical and emotional comfort from families, friends, and others in their community (House, 1981). In western research social support has been found to alleviate the risks of depression, anxiety or Posttraumatic Stress Disorder (PTSD) following traumatic incidents such as violent attack. Results also indicate that perceived or actual social supports are significant protectors of mental illness and mental illness
prognoses, including for people living in lower socio-economic circumstances (Brewin, Andrews & Valentine, 2000). However, the positive effects of social support observed in these western studies often carry the assumption that adequate basic needs are being met. Thus, the research assumes that people have access to the most fundamental of survival needs like water, food, shelter and rudimentary health care. It is yet to be clearly ascertained if perceived or actual social support plays a significant role in the mental health and wellbeing of communities when their most basic of survival needs often remain unmet; as is the case for the majority of people living in developing countries where poverty is a persistent life-stressor and norm.

One line of enquiry relevant to the influences of poverty and social support on people impacted by war is the research focused on migrants from developing countries to western nations. Migration refers to the movement of people between and within different countries, while migrants refer to the people who have experienced those changes in circumstances (Zimmerman, 2008). Migrants often seek asylum and safety in different countries as a result of conflict or extreme poverty conditions (Zimmerman). Studies on asylum-seekers, refugees and migrants have established that these groups experience higher rates of mental illness than their non-migrant counterparts (Steel, Silove, Phan & Bauman, 2002). Fazel, Wheeler and Danesh (2005) estimated that resettled refugee populations in the United States of America may be up to 10 times more likely to develop a mental illness in comparison to their host country residents. This is in spite of migrant communities living in an environment that, for the most part, supports their basic and survival needs and a macro context that is well beyond the poverty line and at times, the devastation of their countries of origin. Further to this, a sense of belongingness to their new cultures and their cultures of origin has been shown repeatedly to improve mental health outcomes in the expansive acculturation research (Leung, 2001; Nesdale & Mak, 2000; Neto, 2002a). Once again, however, research on
migrants has focused predominantly on the experiences of people from developing countries living in westernised societies, where essential basic needs are still considered more readily accessible than in the developing context.

In relation to people who remain in developing countries, such as South Sudan, the World Health Organization (2010) has recognised that those with mental health difficulties are among the most vulnerable in their communities and are commonly excluded from development initiatives or goals. For instance, WHO data suggest that in low-income countries, including South Sudan, depression and malaria contribute almost equivalently to the burden of disease (3.2% and 4% respectively). Whereas malaria results in physical incapacitation for individuals to engage in development initiatives, depression attacks mental wellbeing. This prevents people from supporting themselves or their families in development initiatives, such as agricultural or entrepreneurial programs. Nonetheless, many human and financial resources are invested in alleviating and eradicating malaria and its impact on affected families. In contrast, minimal investment is made in low and middle income countries to mental health challenges, such as depression.

Western research on migrant groups also fails to recognise that the majority of human migration experiences are in fact still within developing country contexts (United States Committee for Refugees [USCR], 2004). The International Organization for Migration ([IOM], 2010) estimates that the total number of migrants has increased substantially in the past 10 years, with an estimated 150 million people living outside their country of birth in the year 2000, to nearly 214 million persons today. In 2009, the IOM estimated that up to 27 million people were internally displaced (living in their birth country but not in their preferred place of residence). In June 2011, the United High Commission for Refugees (UNHCR) reported that approximately 80% of the world’s refugees were living in developing countries. This is a common trend throughout history and in Africa. Examples include the
migration of 2.4 million refugees that fled the 1994 Rwanda genocide (Bryer, 2004), and the massive numbers of internally displaced people from South Sudan who migrated to north Sudan during the civil war (Kemp & Rasbridge, 2004). It is essential, therefore, that research on migration is conducted not only in western contexts, but also in developing contexts, where the vast majority of migration actually transpires. Whether or not the mental health of migrants from one poverty experience to another replicates findings established among people who migrated to developed nations remains to be assessed. Additionally, research on migrants returning to their homelands following conflict is lacking.

The World Health Organisation (2001, 2010) has described a strong link and cycle between poverty and mental health/illness and stresses that the basic needs of people should be included as potential contributors and variables to wellbeing in mental health research. The WHO has explained that people living in poverty and without basic needs are more vulnerable to mental illness, while in a cyclic fashion, people living with mental illness are more likely to experience inequitable access to meeting their basic needs and are therefore forced to endure poverty (WHO, 2010). To account for this link between poverty and mental illness, the current research included basic survival needs as a primary variable, along with social support and considered the influences of migration to and from one developing context and how these factors influence mental health and wellbeing. This is strengthened in the research by undertaking the study in that context (in this instance, in South Sudan), as opposed to assuming that similar findings might result if, for example, studying migrants such as the Sudanese living in an industrialised nation like Australia.

1.5 Overview of mental health and the cultural perceptions of mental illness

In Australia, the government, through its National Mental Health Strategy (2007) has defined mental illness as: “a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people. It is diagnosed according to standardised
criteria. The term mental disorder is also used to refer to these health problems” (p.2). Yet, there is great complexity when considering the constructs of mental health and mental illness for non-western population groups. The ‘standardised criteria’ are claimed to be insufficiently attentive to cultural and contextual issues in the diagnostic process (e.g., Alarcon, 1995; Canino & Alegria, 2008; Lewis-Fernandez & Kleinman, 1995). What is considered mental illness in one culture may not be reflected in other cultures, which Lewis-Fernandez et al. (2010) showed in research about the differing cultural presentations of common anxiety disorders, including Social Anxiety Disorder, Panic Disorder and Generalised Anxiety Disorder. Another commonly misinterpreted psychiatric disorder is psychosis. For example, psychotic symptoms in Australia or America might be indicative of mental disorders such as schizophrenia or psychotic depression, but in other cultures, psychotic symptoms are often believed to be directly related to religious beliefs, as found in Pakistan (Saeed, Gater, Hussain & Mubbashar, 2000) and Egypt (Salib & Youakim, 2001).

It is generally accepted that mental health and mental illness are socially and culturally derived constructs in both the literal and figurative definitions (De Jong, 2002). Malgady and Zayas (2001) also pointed out that linguistic variations of nationality or tribe contribute to the conceptualisation and expressions of distress. Though advocates of the DSM-IV-TR (APA, 2000) believe improvements were made with the inclusion of the Cultural Formulation and Glossary of Culture-Bound Syndromes, many researchers maintain that DSM-IV-TR’s taxonomy remains flawed, inapplicable to non-western culture and mixed in its implied messages of being universally relevant (Alarcon & Foulks, 1995; Canino & Alegria, 2008; Miranda & Fraser, 2002; Thakker & Ward, 1998). Thakker and Ward suggested that western methodologies and discrete categorisation of mental disorders undermines indigenous knowledge and argued that cross-cultural research approaches rarely do justice to social and cultural conceptualisations of illness. Nevertheless, implied messages
and the suggested utility of the DSM-IV-TR maintain that mental disorders have similar manifestations in all cultures, but it is strongly recommended by researchers that qualitative explanatory models of illness and the varying cross-cultural beliefs surrounding them form an essential component to any cross-cultural research design (Andary, Stolk & Klimidis, 2003).²

Prior cultural analysis clearly indicates that any studies of mental illness or wellbeing in non-western contexts ought to provide an opportunity for people to express their experiences or distress in their own words and in ways that are customary to their cultures. It should also explore how local people perceive their problems in the context of their daily lives (e.g., living in poverty or in a post-war context), which has the potential to reveal stronger influences on the mental health and wellbeing of individuals than stand-alone diagnostic mental illnesses. Solely seeking confirmation of disorders based on questionnaires or western taxonomies like the DSM-IV-TR is unlikely to fully capture the localised perception of illness or wellbeing. The current study opted, therefore, for a mixed methods research design to include two studies – a quantitative and a qualitative study – that enabled research participants to share their own perceptions of mental health and illness in their own language, and to incorporate within that the cultural and poverty context in which the people of South Sudan live.

1.6 The South Sudan context

Prior to the independence of The Republic of South Sudan, the combined north and south regions that made up the original nation of Sudan was Africa’s largest country. In the northern regions it bordered Egypt to the north, the Red Sea, Eritrea and Ethiopia to the east.

² At the time of this study, the DSM-IV-TR (APA, 2000) was the latest American Psychiatric Association (APA) diagnostic manual. Since then, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V; APA, 2013) has been published. The DSM-V has revised the description of “Cultural Issues” (p.14) and the “Cultural Formulation” (p.749) to offer greater detail about cultural factors that may contribute to the presentation, diagnosis and treatment of mental disorders. Debate from the DSM-IV-TR about shortcomings of the poor representation of cultural issues in the diagnoses of psychiatric disorders is likely to remain applicable to the DSM-V. Therefore, the DSM-IV-TR will be used as the point of reference for this study since it was the most recent diagnostic manual published at the time of the research, analysis and reporting.
In the southern regions, South Sudan is bordered by Kenya, Uganda, Democratic Republic of Congo, Central Africa Republic, Chad and Libya. The official capital of Sudan was initially Khartoum, though the burgeoning city of South Sudan’s Juba is now the capital of The Republic of South Sudan. Although the complete and official border demarcations between north and South Sudan remains to be legally determined, the map provided in Appendix A outlines South Sudan’s 10 states, plus an overall perspective of north and South Sudan prior to and following the South’s independence.

As a nation, Sudan has suffered natural and man-made disasters for generations: political oppression, famine, floods, locust plagues and enduring tribal and civil conflict. Since its independence from Britain in 1956, Sudan almost continuously experienced civil war (Kemp & Rasbridge, 2004). The first north-south conflict ended in 1972 (lasting approximately 16 years), but restarted just over 10 years later in 1983; until the signing of a Comprehensive Peace Agreement in 2005. This latter war, largely between the fundamentalist Islamic government of Khartoum against the diverse ethnic groups and Christians in the south, raged for nearly 22 years (Central Intelligence Agency [CIA], 2009) and has been commonly marked as Africa’s longest civil war (Johnson, 2011).

John Garang de Mabior was one of the most renowned Southern Sudanese political leaders, directing the Sudan People’s Liberation Army (SPLA) to the 2005 peace agreement, and in many southerners’ minds, to the ultimate realisation of independence – even though John Garang never saw that independence following his unexpected death in July 2005. John Garang is frequently referred to as a shining hero of South Sudan, although some tribes viewed him as a rebel responsible for the longevity of the war and inter and intra tribal dissonance (Scroggins, 2002).

During wartime between 1983 and 2005, the international community was outraged with northern military leaders who prevented food and relief supplies to regions of the south.
This resulted in the great famine from 1987 to 1989, when more than 250,000 people died from starvation (Kemp & Rasbridge, 2004). Continuously limited humanitarian access for United Nations (UN) agencies and international non-government organisations (iNGOs) led to even greater hardships for the people of South Sudan. There was only restricted development of infrastructure, markets, health systems and other essential services like education, water, housing and roads, which all came to a standstill during wartime. In total, over two decades, this second civil war claimed the lives of nearly 2 million people and a further four million people were displaced within the Sudanese borders and internationally (Kemp & Rasbridge). Many South Sudanese people sought refuge in neighbouring countries including Kenya, Ethiopia, Uganda and Egypt. Countless others moved to the northern Sudanese regions, including Khartoum, where they were closer to vital and life-saving provisions through the establishment of refugee and Internally Displaced Persons (IDP) camps.

The north-South Sudan civil war finally ended with the signing of a Comprehensive Peace Agreement (CPA) in January 2005. The agreement negotiated an autonomous South Sudan government to be established for a six year transition period before the promise of a referendum for independence from north Sudan (CIA, 2009), which was held in 2011. The peace process was further complicated by the resurgence of the north Sudan-Darfur conflict in 2003, along with the issue of an arrest warrant for the Sudanese President by the International Criminal Court in March 2009 (British Broadcasting Corporation [BBC], 2009). Nevertheless, under international political pressure, South Sudan voted to secede from the north in January 2011, with independence granted on 9 July 2011 and international recognition of the world’s newest nation – The Republic of South Sudan. The South’s freedom from the north has come at a cost however, with the peace seen during the terms of the CPA no longer observed.
In a recent update from the United Nations Secretary General of South Sudan, (United Nations Security Council, 2013) it was reported that continued north-south political tensions that remained unresolved from the terms of the Comprehensive Peace Agreement have characterised and adversely challenged South Sudan’s first few years of independence. In particular, border demarcations, oil revenues and transit fees and the fate of contested states, particularly Jonglei and Abyei, have resulted in extreme economic hardship and lack of safety for the majority of Southern Sudanese people living along the north-south border regions. Furthermore, the rest of the Southern Sudanese people have endured erratic rains that have impacted food security, national austerity measures to reduce the fluctuating value of the Southern Sudanese Pound and limited humanitarian access (due to insecurity). Border states have also reported greater than expected refugee and IDP influxes, including from northern Sudanese conflicts in the Blue Nile, with South Sudan’s state of Upper Nile.

Although these are devastating times for South Sudan, the period in which the current research engaged in data collection was January 2008 – a time when the Southern Sudanese were hopeful about future independence, people were willingly returning to their homeland following decades of asylum, and under the terms of the Comprehensive Peace Agreement. This relative peace was dominating the majority of the South Sudan landscape. While the security and refugee contexts of Malakal and South Sudan’s Upper Nile state (where the current research was based) has altered since this research was instigated, the central constructs and ideas being examined herein remain relevant to consideration of the influences of mental health and wellbeing in this poverty and conflict-affected region. The current research findings from that relatively peaceful time might even be more relevant now given renewed conflict and oppressive poverty conditions that have emerged since South Sudan’s independence.
In South Sudan, life and survival (then and now) continues to be a daily struggle for the Southern Sudanese people. The Human Development Report/Index ([HDI] UNDP, 2010) – a composite measure of three aspects of human development including health, education and income – estimates that Sudan sits at number 154 out of a possible 169 nations measured on the HDI in 2010 (compared with Australia at number 2 out of 169 nations). This finding signals that life in South Sudan is amongst the worst quality and most at risk for mortality and health morbidity than most other countries in the world. Based on the whole of Sudan figures (north plus south), life-expectancy is low at an average of 51.42 years and approximately 82 children out of 1,000 live births die before their 5th birthdays. Although the overall Sudanese national income is high for an African nation, due to major oil exports, very little of this is realised by the average Sudanese person who earns no more than USD $1,200 per annum (CIA, 2009). It is significant, however, that these figures are not representative of South Sudan as a discrete region or country. Prior to 2008 when the current research occurred, the last published census figures from Sudan dates back as far as 1956. Therefore, all population figures usually include the more educated and wealthy northern Sudanese people, which inflates the key development and income indicators of the south.

In May 2008, a new census was undertaken in Sudan aiming to separate key statistics between the northern and southern states (BBC, 2009). This census focused largely on gathering population figures in preparation for the 2011 referendum. It suggested that the total population of Sudan (north plus south) was approximately 39 million people, of which 8.2 million people were believed to be living in the south. This figure is widely contested with the Government of South Sudan believing the population in the south may be as high as 11 million people. There is only estimated data on the percentage of the South’s population

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3 2008 census data was not published at the time of writing. Due to political sensitivities regarding outcomes of the data, its publication was already late and estimated to be available in early 2010 (BBC, 2009). However, publication of this data never eventuated.
currently living below the poverty line, which the United Nations Development Program (UNDP, 2010) considered to be 50.6% of people; or every second person.

The signing of the Comprehensive Peace Agreement (CPA) in 2005, followed by the 2008 census data collection, a referendum for independence in January 2011 and the subsequent succession of South Sudan from the north on 9 July 2011. Over this time the Governments of north and South Sudan have been encouraging displaced Southerners to return to their southern homelands to support the enormous development needs of their emerging nation. Returnee numbers during the CPA period were lower than expected and largely spontaneous (meaning many returnees did so of their own volition and with minimal UN or government support). Yet, since independence and the upsurge of violence in the north-south border regions, most Southern Sudanese living in the north of Sudan have begun their return home. The Office for the Coordination of Humanitarian Affairs ([UN OCHA], 2012) estimated that more than 400,000 Southern Sudanese people have returned since 2010 with many more expected to arrive over the coming months and years. Therefore, considering the wellbeing and influences of mental health for all people in South Sudan, including those who remained in south Sudan throughout the civil war and the unique challenges of those recently returning to their homeland, this research is both important and relevant to the current South Sudan humanitarian landscape.

The Internal Displacement Monitoring Centre ([IDMC], 2011) confirmed that the slower than expected returnee process during the 2005-2010 Comprehensive Peace Agreement phase was because many Southern Sudanese people opted to remain in refugee or IDP camps where they had easier and more regular access to humanitarian support. This included easier access to health services, food, water and education than in their severely under-developed country of origin. It is common for humanitarian aid to reach displaced populations with basic needs and services, particularly the essentials of food, water, shelter
and healthcare, whereas displaced families returning to homelands are expected to become personally responsible for meeting their own needs. Nonetheless, at the time of data collection for this research, some returnees were ‘coming home’ and resettling to life in their Sudanese states and tribes of origin. As with all population movements however, it was also expected that many returnees would and had migrated to more populated areas and townships, such as Malakal, because UN agencies and iNGOs tend to operate in such populous regions and returnees would still have greater access to humanitarian assistance.

As previously mentioned, the 2008 census revealed some South Sudan population statistics, but it failed to comprehensively describe the quality of life for the Southern Sudanese people specifically. Therefore, information about South Sudan and the extent of poverty is largely based on assessment information gathered by United Nations agencies and international non-government organisations (iNGOs) currently operating in South Sudan. Based on their work, it is accepted that data from the south is much worse than overall national averages. Information indicates that the majority of the Southern Sudanese people live in abject poverty and having access to basic needs and services is a daily battle.

It is estimated that the average Southern Sudanese’s income is about USD $530 per annum, and the under-five mortality rate is as high as 22% in some regions (United Nations International Children’s Fund [UNICEF], 2010). With less than 2,000 primary schools in South Sudan, literacy is considered one of the world’s lowest with no more than 25% of the population having a basic education, with a much higher percentage of boys educated than girls (UNICEF, 2010). To provide a context for these statistics, they compare to Australia’s individual average income of approximately USD $43,590, an under-five mortality rate of just 0.5% (World Bank, 2011), and it is estimated that 97% of Australian children are enrolled in primary education (as at 2009, UNICEF, 2010) in some 6,300 primary schools nationally (Australian Bureau of Statistics, 2010). By all objective measures of poverty, there
is no question that the majority of people living in South Sudan are surviving poverty conditions and South Sudan is one of the least developed nations of the world (HDI, 2010).

Key statistics on the health infrastructure in South Sudan are also difficult to obtain due to frequent changes of iNGO activities and funding. Nevertheless, in 2009, the WHO estimated that there was only one hospital per 431,000 people, one Primary Health Care Centre per 79,500 people and one Primary Health Care Unit per 15,000. They reported that all facilities were in poor condition, staff urgently required training and because funding for wages was not always available through the government, many of the health facilities were not regularly or reliably operational. Statistics about mental health services in South Sudan have not been methodically analysed. However, a systematic review of international mental health systems by Jacob et al. (2007) revealed that for the whole of Sudan (north and south combined), there is only an estimated 114 mental health care providers per 100,000 people; and despite the existence of mental health care legislation and policy, only one psychiatrist available per 1.2 million people. When extrapolated out, this represents less than 33 psychiatrists for the whole nation and it is widely believed that almost all psychiatrists operate from the northern Sudan regions.

It is clear that the people of South Sudan are disadvantaged and struggle with many life-challenges including, but not limited to, finding sufficient and nutritious food, accessing safe drinking water, building adequate family shelters and having access to education and health care. One region of South Sudan, which is the focus of research in this thesis, is the state of Upper Nile. The Upper Nile continues to be a contested border region between north and South Sudan, as well as an area impacted greatly by poverty and population movements. With so many people attempting to access basic needs and services, it has a growing township in and around the Malakal area.
Malakal is typical of many southern Sudanese towns that have now opened up to trade with north Sudan along the Nile River system and surrounding countries. The majority of the population live along the White Nile and rely on subsistence farming or agriculture as a source of livelihood. The main tribes of Upper Nile include the Nuer, Nasir and Shilluk people who speak various local dialects that all derive from traditional Arabic languages. The predominant religions in this region are Muslim and Christian, though this is usually combined with assorted animistic and traditional spiritual beliefs that influence daily culture, traditions, social support structures and health-seeking behaviours (Kemp & Rasbridge, 2004). One of the more unique features of the Upper Nile region of South Sudan is the Nilotic tribe and Kingdom of the Shilluk people, which consists of the third largest tribe in South Sudan (followed by the Dinka and Nuer tribes).

The Shilluk monarch and tribe were initially studied by Charles Seligman (1911). History and local folklore believe the kingdom to have begun in the mid-fifteenth century with the ‘Reth’ as the ruler or King of the tribe. The King’s health was seen to be interdependent with the health of the tribes-people and the monarch was looked upon for direction of social tradition and social order. The Shilluk King was observed to be a highly revered and respected ruler of the Shilluk people and lands, until such time as British colonisation saw the Kingdom merge with the broader Sudan and Christian missionaries converted the majority of the tribe to Catholic or Protestant beliefs. In the modern day Republic of South Sudan, the Shilluk King holds some administrative authority with the current Upper Nile State government. Yet, despite the Shilluk Kingdom no longer functioning as an autonomous political entity, it remains highly sacrosanct to its people and looked up to for chieftain authority for the Shilluk people (J. Yor, personal communication, February 2008).
Another important social structure in South Sudan, including the Shilluk and Upper Nile tribes is the composition of gender roles. As part of the United Nations Consolidated Appeals Process ([UN CAP], 2011), a brief gender analysis in South Sudan confirmed the patriarchal nature of Sudanese gender roles. Men are perceived to be heads of household and broadly in charge of familial order. As such, women bear the greatest burdens in families. Polygamy is common throughout South Sudan where marital order (e.g., first and second wives) can sometimes create discord. Women are considered the primary carers of children, including extended family children and are thus frequently excluded from education and economic opportunities. Women also work in family harvest plots and are usually responsible for maintaining the home, collecting water, firewood and meeting the other tangible familial needs. Early and forced marriage of girls is common, while incidents of female genital mutilation (or circumcision) are also reported along with its subsequent health implications, particularly during childbirth (Kemp & Rasbridge, 2004). As is common during conflict and population displacement, women have been reported to be at greater risk of sexual and gender based violence, including rape from armed parties, domestic violence in the home and continued enforcement of traditional practices that aim to maintain family honour, such as requiring girls or women to marry a rapist or women being imprisoned for adultery (UN CAP, 2011). More recent reports from South Sudan have noted that returning and displaced households are disproportionately female headed, despite the cultural practice that women are expected to rely on the graces of their husbands and husbands’ families and therefore are, at times, prevented from seeking regular employment. While it is undeniable that the poverty conditions in South Sudan impact on both men and women, the nature and traditional social order of women places them in a particularly vulnerable position that would include stress and subsequent mental illness or poor mental wellbeing. However, women and their traditional roles are also being reported as being challenged as women are finding ways
to contribute to the task of developing South Sudan and meeting its demands as an independent state (United States Institute of Peace [USIP], 2011).

In many social and contextual ways, Malakal, the main township where this study was based, might be considered typical to the rest of South Sudan. Government priorities for this region involve meeting the basic humanitarian needs of its people. The Government of South Sudan and humanitarian concerns include the continued safety and security of the local population, including women and girls, resettlement of returned families, and a range of recovery and development activities in the sectors of roads infrastructure, education and vocational training, food aid, food security and livelihoods recovery, health, nutrition, water and sanitation, protection and realisation of human rights and governance and rule of law (United Nations [UN] & Partners, 2006). Collectively, such priorities and needs might be referred to as “basic needs”, which is outlined further and more specifically defined in the proceeding sections.

Based on known and estimated statistics about South Sudan and the daily challenges people face when living in such poverty, the people of South Sudan have many concerns that potentially impact their mental health and wellbeing. These go well beyond simply the impacts of the civil war and their fight for independence from the north. Like many other unknowns in South Sudan, targeted epidemiological data about mental illness is not available. Mental health and mental illness incidence and prevalence information has not been recorded or analysed. Therefore, despite the likelihood of cultural differences between western and Sudanese perceptions of mental health, wellbeing and mental illness, the lack of data from Sudan requires us to consider mental health from western perspectives first; to consider how mental health is construed in the west and how that may or may not relate to the experience of people living in South Sudan. As well, it is important to establish what is known in the
literature about refugee experiences and how war, trauma and migration influence mental health and wellbeing. These areas are addressed in the following chapters.
CHAPTER 2: ASPECTS OF MENTAL HEALTH IN DEVELOPING CONTEXTS

2.1 Defining mental health

Mental health is one component of health, while illness relating to mental health is referred as either mental illness or mental disorder. In Australia (National Mental Health Strategy, 2007) mental illness is defined through diagnosis of a disorder and its compatibility to standard criteria for illnesses. However, using an internationally recognised definition of health, mental health is encompassed by the World Health Organisation (1948) as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or presence of infirmity” (p.1). This international definition of health recognises the interaction of the biological, psychological and social (often referred to as biopsychosocial) aspects that humans require to attain maximum levels of health and wellbeing.

Mental health as a singular entity is much more difficult to define given its evolution over years of philosophical, sociological and anthropological thinking, and is evidently shaped by differing and changing cultural attitudes, perspectives and traditions (de Jong, 2002; WHO, 2001). The WHO indicates that concepts of mental health vary from ideals of subjective wellbeing to perceived autonomy, self-efficacy and functionality to more sophisticated or spiritual concepts such as self-actualisation, internal peacefulness and emotional maturity. Yet, despite recognition that mental health is an interaction of biopsychosocial factors, mental health researchers have historically found it more pragmatic and generalisable to follow the traditional biomedical approach and nomenclature such as that found in the Diagnostic and Statistical Manual (DSM), and to a lesser extent, diagnoses found in the World Health Organisation’s International Classifications of Diseases (ICD)-10 Classification of Mental and Behavioural Disorders (ICD-10; 2007). Historically, the majority of cross-cultural research and literature has referred to the DSM taxonomy rather
than the ICD-10. Consequently, this study also uses the DSM as its guiding biomedical reference, in addition to the benefit of the DSM-IV-TR (APA, 2000) incorporating the Cultural Formulation, which was used as an integral component of this research design.

Biomedical approaches to mental illness examine the signs and symptoms of illness, including psychological distress, and compare them with a set of diagnostic criteria. With the exception of some disorders (e.g., Posttraumatic Stress Disorder), most psychological diagnoses do not consider the causes of mental disorder or distress, such as life stressors or life changes, which may potentially influence the illness (Verhulst & Tucker, 1995). On the other hand, a biopsychosocial approach is often considered a more robust and multifaceted way of perceiving illness and health, acknowledging that many factors (physiological, psychological and social) contribute to wellbeing (Engel, 1977; Melchert, 2011).

To further analyse the biomedical taxonomical approach, it is important to consider its underlying goals. The DSM describes its purpose as being “to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people” (DSM-IV-TR, APA, 2000, p.xxxvii). Since its inception, the DSM and its identified goal has arguably proven to be extremely useful and is well-utilised in the vast majority of post-modern psychological and psychiatric research initiatives. However, in relation to cross-cultural research, using a biomedical and western delineated model of mental illness has been acknowledged as problematic (Thakkar & Ward, 1998).

2.2 Cultural measurement and perceptions of mental health/mental illness

Kleinman (1977) claimed that it was a fallacy for DSM disorders to be categorically paralleled from one culture to another and that in the search for likeness, researchers ultimately neglected the extent or social complexity of cultural differences. Kleinman and Cohen (1997) cite depression as one example. They reported that depression in western societies presents with more psychological states, such as feelings of despair or sadness, but
that in non-western societies, particularly traditionally oriented ethnic groups, the presentation of depression has greater emphasis on physical symptoms such as headache or fatigue. Kleinman and Cohen went on to explore whether such diverse presentations of depression were revealing the same mental disorder (depression) with differing manifestations and symptoms, or if the presentations were suggestive of an alternative mental illness. They examined a lawyer in New York and a tribesman in Nigeria and concluded that diagnostic criteria for each culture were too diverse and not closely enough matched to be classified as the same disorder.

Kleinman and Cohen (1997) acknowledged that their studies and references required further validation and continued research. They did not posit that biology played no role in mental illness, but focused merely on the extreme differences that can be apparent when using a biomedical based classification system such as the DSM. They advocated for the importance of being inclusive of biology as well as other social and cultural factors when exploring mental illness in non-western contexts. Jones and Craddock (1997) supported the need for cultural sensitivity in mental health research, but indicated the importance of recognising that people of all cultures share a universal physical biology and as such, while mental illness may manifest in different ways according to cultural and social influences, the illnesses warrant ongoing concern and treatment options, inclusive of indigenous healing traditions.

Views and concerns about categorical fallacies in mental illness were also presented by Thakker and Ward (1998) as they expanded on the arguments of Kleinman (1977) and Kleinman & Cohen (1997). Thakker and Ward suggested that western methodologies and categorisation risked undermining indigenous knowledge systems by attempting to “fit” western ideals to unrelated cultural perceptions of mental illness. Thakker and Ward claimed that cross-cultural variations in symptomotology were perceived by the biomedical-based
DSM as superficial and unimportant, but that the underlying biological changes in relation to mental illness was perceived as the disease itself – thus devaluing culturally held beliefs about illness and its causes. The authors further asserted that in attempting to justify global and biomedical approaches to mental illness, it constrained learning by overlooking traditional beliefs, behaviours and symptomotology of other cultures. For example, Mbatia, Shah and Jeenkins (2009) found that people in Tanzania viewed the onset of depression as a way for people with low stamina to cope with life difficulties. Research participants believed that therapeutic approaches through primary health care interventions would be more efficacious for treatment than antidepressants because, in their view, treatment had to focus on improving a person’s stamina, not just improving their mood. Thus, with each culture likely to construe mental illness and wellbeing differently, and with the presentations of illness, idioms of distress and treatment options being culturally relative, measuring mental health remains enormously challenging. This is particularly true in poorly researched contexts such as South Sudan where the mental health literature is scant.

One alternative that is growing in acceptance with cross-cultural psychology is the concept of dimensional approaches to evaluating mental illness (Alarcon & Foulks, 1995; Thakker & Ward, 1998). Such models were tested in preparation for the publication of the DSM-5 and beyond (Lara, Pinto, Akiskal & Akiskal, 2006). These dimensional approaches show potential for generating more culturally responsive systems in measuring the variants of severity and presence of psychopathology, which could be subsequently illustrated as a measure of mental health according to a continuum of symptoms. This method of measuring illness as a continuum, rather than categorisation, as the current DSM-IV-TR attempts to do, also supports recommendations long held by Thakker and Ward who proposed that psychological taxonomies should focus more on symptoms and their variants than on specific diagnoses. In the context of South Sudan for instance, people experiencing mental ill-health
may present with symptoms that are dimensionally different to those identified by the DSM-IV-TR. Using depression as an example, the Southern Sudanese may perceive symptoms of social isolation as being more deleterious than an overall low mood, weight changes or feelings of guilt.

Based on cultural debates about the pitfalls of categorical measurement of mental illness, it appears justified this thesis measures common mental illnesses as a continuum of symptoms, particularly for a sample group living in a non-western context like South Sudan, where local presentations and perceptions of what constitutes mental health and mental illness may not “neatly fit” with the biomedical diagnostic categories of the DSM-IV-TR (APA, 2000). As suggested by Kleinman and Cohen (1997), traditional Southern Sudanese people may experience common mental illnesses like depression, anxiety or war-related Posttraumatic Stress Disorder more physically than psychologically, or it may be the outcome of how people interact in their traditional/communal systems and how they cope with their physically impoverished environment.

One of the challenges facing dimensional measures of mental illness is the point at which mental illness and mental health can or should be distinguished. The construct of mental health (as opposed to mental illness) and an agreed definition lacks consensus in the mental health literature (Herron & Mortimer, 1999). Mental health and mental illness are often viewed as unipolar opposites, where both are seen as each end of a continuum (Herron & Trent, 2000). Coming from this theory is the idea that a person may actually experience their mental wellbeing at any point of the continuum, whether their experiences reflect a diagnostic disorder or not (Prager & Scallet, 1992). This continuum is sometimes referred to as a dual-factor model or dual-continua model of mental health. Keyes (2005) suggested this might be described as those who are perceived as “flourishing” in contrast to those “languishing” and struggling to sustain a sense of wellness. Keyes described symptoms of
flourishing as states and experiences in life such as positive affect, life satisfaction, self-
acceptance and, among other things, self-mastery, life coherence and positive relationships. In contrast, Keyes described symptoms of languishing as struggling to achieve the symptoms of flourishing, but that this did not necessarily equate to mental illness. In other words, Keyes suggested that, in line with the World Health Organization’s (1948) definition of health, mental health was more than the mere absence of mental illness and that people experiencing classified illnesses, like depression or anxiety, did not constitute a homogenous group; rather, individuals in Keyes’ study that did not attain a status of flourishing were sometimes experiencing similar levels of life-dysfunction and distress as those who were classified as mentally ill. A continued weakness of this model, however, is that at some point, a cut-off between languishing and flourishing would be necessary and in the process, somewhat defeats the notion of a continuum rather than a classification.

In a study of school-aged American youth, Suldo and Shaffer (2008) used a dual-factor model of mental health to assess positive indicators of wellness like subjective wellbeing, and traditionally viewed negative indicators of illness, including internalising psychological disorders such as depression and anxiety plus externalising disorders, like oppositional defiance disorder and conduct disorder. Suldo and Shaffer referred to these disorders as traditional negative indicators of mental health, or psychopathology. Using dimensional measures they calculated aggregate subjective wellbeing scores and aggregate psychopathology scores. The results supported the concept of a dual-factor model and dimensional measures with 57% of the sample ($n=349$) indicating complete mental health and 17% suggestive of some psychopathology that warranted follow up. However, the study went beyond the unipolar opposites of mental illness and mental health. It further identified two other groups on the wellbeing continuum; a group that were vulnerable to illness (13%) and another group that demonstrated symptoms of mental disorder but still reported
subjective wellbeing (13%). Suldo and Shaffer’s findings were supportive of those previously submitted by Keyes (2005) stating that mental wellbeing is more than merely mental health and mental illness, but further constitutes many variations of wellbeing along the continuum.

Based on his own study of American adults, Keyes (2005) identified some limitations to the dual model approach of measuring mental health and wellbeing. He noted that some diagnostic measures for mental disorders may not be adequately rigorous nor replace a full diagnostic interview. He also noted that measures of subjective wellbeing could not be conclusive across cultures. Indeed, the measures in Keyes’ own study were biased toward western and developed nation constructs of wellbeing, with indicators like autonomy, a sense of life-happiness and self-acceptance. Such attributes of wellbeing may be less important in collectivist or tribal cultures where a sense of belonging or community may be held in higher esteem. Keyes further reported that the validity of the diagnoses or the cut-off scores used in the measures for mental illness required further work and substantiation. Keyes’ study focused on diagnostic cut-off scores based on DSM-IV-TR (APA, 2000) criteria, but Keyes noted that presentation of mental illness and the emphasis of certain symptoms for those illnesses may be different in non-western cultures.

Despite the realities of imperfect approaches to psychological and wellbeing measurements, Keyes (2005) and others (e.g., Suldo & Shaffer, 2008) have shown the potential of viewing a continuum as a reasonable measure for mental health and wellbeing in a research sample. In a cross-cultural research sample, such as the southern Sudanese sample studied in this research, a continuum of wellbeing based on symptoms of illness has many benefits. These included not being forced to validate cut-off scores for diagnoses, not viewing mental health and mental illness as dichotomous constructs and enabling a general impression of wellbeing as opposed to relying on the specificity of clinical measures. Given
the consistent views that pure diagnoses in non-western samples are inadequate for including cultural variations of symptoms and localised perceptions of both mental illness and subjective wellbeing (Keyes, 2005; Kleinman, 1977; Thakker & Ward, 1998), this thesis emphasised using a continuum measure of mental health and wellbeing. Any attempt to pursue precise or epidemiological data on mental illness in South Sudan was beyond the scope and aims of this investigation. In doing so, the first quantitative study looked at mental health and wellbeing as a continuum of symptoms (as opposed to a diagnosis), while the second qualitative study looked at the localised perceptions of mental illness as a broad concept, without referring to an explicit illness.

Although approaching mental health on a continuum provides flexibility to a cross-cultural sample, aspects of measurement for the quantitative analysis requires particular consideration. For example, determining what might influence mental health and wellbeing for different groups in South Sudan, and what elements of mental illness might suggest ill-health or poor wellbeing. To consider the appropriate measures for this South Sudan sample group, it is relevant to explore what is already known about the mental health and wellbeing of people in other parts of the world who have also experienced war, poverty and migration.

2.3 The experience of displacement and forced migration

Migration is the broad term used to describe the movement of populations between and within different countries. Forced migration refers to people who have had to flee their homes for reasons usually related to their survival, safety or wellbeing (Zimmerman, 2008). In accordance to Article 1 of the 1951 UN Convention in Relation to the Status of Refugees (United Nations General Assembly, 1951), a refugee is any person who has fled from and/or cannot return to their country of origin due to a well-founded fear of persecution, including war or civil conflict. This is slightly different to an Internally Displaced Person (IDP), who is legally protected under the Guiding Principles on Internal Displacement (United Nations
Economic and Social Council [UN ECOSOC], 1998) and reflects people who may have been forced to flee their homes, often for the same reasons as refugees, but who have not officially crossed a recognised international border. The experience of forced migration and displacement is commonly described as traumatic based on the causes of migration, the poor conditions faced during exile and the challenges of either resettling to a new country or returning to homelands (Ingleby, 2005).

Van der Veer (1998) provided a brief outline of the most common refugee or IDP journeys and stressed that refugees and IDPs not only experience armed conflict, persecution, personal attack and sometimes torture prior to their escape from their native homes, but they usually endured long and physically taxing voyages to places of refuge. Family separation is commonplace along with loss of all personal possessions. Once in the so-called ‘safety’ of a refugee or IDP camp, the hardships continue. People are effectively living in exile and it is frequently reported that their freedoms of movement and other fundamental human rights are violated, despite the protection mandates of the United Nations Humanitarian Commission for Refugees (UNHCR). Refugee and IDP camps are renowned for being overcrowded, limited in their services, and hotspots for domestic, interclan or host community violence (Merali, 2008). Refugees and IDPs also rarely have a sense of control over what happens in their lives, in conjunction with limited views of the future and uncertainty about their resettlement options even after long periods of asylum. UNHCR (2007) reported that the average time for refugees to remain in camp environments prior to resettlement or returning to their homelands is about 17 years. This has been similar in the case of Southern Sudanese people who fled the war and its various consequences with many having spent the majority of their lives outside their native country, with some youth having never lived in their ‘home’ country (A. Schafer, personal communication, January 2006).
The mental health and wellbeing of people living in refugee and IDP camps has been an area of growing research and concern. This has been in light of recognition that refugees and IDPs constitute a much larger number of people worldwide than voluntary migrants (UNHCR, 2011a). In 2010 the United Nations High Commission for Refugees ([UNHCR], 2011a) reported that by the end of 2010 close to 43.7 million people had been forced to migrate throughout the world, with the majority (27.5 million people) trapped within their own borders as IDPs. Of the 15.4 million refugees worldwide, the developing nations of Pakistan, Kenya and the Democratic Republic of Congo hosted the largest numbers of refugees (in relation to the size of their economies).

Following a surge in the numbers of refugees seeking resettlement or asylum in developed countries during the 1980s and 1990s, this period also saw an expansion of mental health research amongst these population groups (Ingleby, 2005). For the most part, studies focused on two aspects of refugee mental health: their challenges of acculturation and adaptation to their new societies (usually to western-nations), which are discussed later (p.35); and psychopathology. While studies about refugees’ mental health concerns consistently revealed higher psychopathology amongst refugee groups living in the west than their host nation counterparts (Fazel, Wheeler & Danesh, 2005), researchers quickly realised that this was a minor concern because the main burden of refugee and IDP populations were still living in low and middle income countries (USCR, 2003). Hence the next wave of psychopathological and epidemiological studies followed amongst refugees and IDPs in Middle East, Asia and Africa. Once again, like the mental health research focused on refugees and IDPs in developing countries, a resurgence of studies in developing countries continued to focus on a biomedical model to issues of trauma/Posttraumatic Stress Disorder (PTSD) and depression/anxiety (Ingleby, 2005). There was little focus on overall wellbeing or the influences of the contexts (often poverty conditions) in which people were enduring.
(Summerfield, 2001). Therefore, to date, the majority of research into refugee mental health, specifically in developing countries, has been limited in its scope and riddled with challenges regarding its relevance, applicability and usefulness (Summerfield, 1997, 2001). Demonstrating this, a study by van Ommeren et al. (2002) looked at the links between somatic complaints in primary health settings and the diagnoses of Posttraumatic Stress Disorder (PTSD) among Bhutanese refugee and torture survivors living in Nepal ($n=526$). This study found strong links and predictors for PTSD diagnoses (such as intensity of torture, female gender and higher age), but their findings were not comprehensive because they used non-validated western measures and employed the diagnostic criteria of the western-delineated biomedical taxonomy of the DSM-Third Edition (DSM-III).

### 2.4 The stress of acculturation and adaptation among refugees living in developed countries

Acculturation is a term used to describe cultural changes resulting from direct contact between two cultural groups. Evolving from the same idea, psychological acculturation is more specific in reference to the psychological changes that derive from an acculturative experience (Catwe, Bianchi & Kiloh, 1968). These concepts of acculturation are potentially important in the current research in South Sudan, particularly in light of many returnees to South Sudan having spent so many years living in a culture outside of their homeland. Acculturation and acculturative experiences may contribute to understanding some of the likely psychological changes for the people of South Sudan, particularly returnees. Some Southern Sudanese people will have endured two acculturation experiences: first as they adapted to the cultures they lived in during their time of displacement; and second, how they faced further cultural change when they returned to their homelands and attempted to re-integrate a new era of South Sudan as an independently governed nation.
Berry (Berry, Kim, Minde & Mok, 1987) has been one of the researchers bringing the concept of acculturation to the forefront amongst migrant people to northern nations, many of whom had also come from low and middle income backgrounds. Berry described a model of four commonly used approaches to the ways ethnic groups adapt to cultural change. These strategies were described as: Assimilation, Integration, Separation and Marginalisation, as depicted in Figure 1 below.

Based on Berry’s (1987) acculturation strategies, the four approaches observed among ethnocultural groups can be interpreted as different ways of adapting to the new culture, with varying intensity. Integration involves an incorporation of the new culture, but a sustained and maintained identity with the culture of origin. In the context of the dominant group, usually the host culture, this is viewed as leading to the multiculturalism of ethnic groups and society. Based on the literature, integration is the ideal context for host and migrant groups, with the majority of societies, at least in the developed world, aspiring towards this.
Assimilation occurs when people relinquish their own ethnic identity and adopt that of the new dominant society. The loss of multicultural appreciation is perceived to lead toward a metaphorical ‘melting pot’ where the different cultural elements melt together creating greater cultural homogeneity. However, the downside to assimilation can be the loss of social multiculturalism, where the benefits of shared ethnicities, which can lead to greater cultural tolerance and acceptance, are absent.

Separation refers to a form of segregation where either the new ethnic group fails to engage with the larger society or when larger society implicitly or explicitly imposes separation. Marginalisation occurs when the cultural group loses connections with their own culture and fails to engage with the new culture, often leading to exclusion of the minority by the majority cultures. Marginalised groups tend to experience a loss of cultural identity and often experience strong feelings of isolation and alienation (Berry, 1992, 1997; Al-Issa & Tousignant, 1997). Berry’s research suggests that migrants experiencing separation and/or marginalisation are more prone to social seclusion and as a result, mental illness.

To determine the impacts of acculturation and predictive factors identifying the four acculturation strategies, Berry and colleagues ascertained that a measure of “acculturative stress” could be validated to explain poor adaptation or acculturation amongst ethnic groups. Acculturative stress refers to the psychological and somatic stress reactions that occur in response to experiences rooted in the acculturative process, as migrants are integrated, assimilated, separated or marginalised within the dominant or host society (Berry, 2006). Berry identified that people experiencing separation or marginalisation in their new cultures were more prone to experiencing greater acculturative stress.

Based on The Acculturative Stress Scale of Cawte, Bianchi and Kiloh (1968) and updated by Berry, Kim, Minde and Mok (1987) and Neto (1994), this parsimonious scale listed 10 somatic symptoms and 10 psychological symptoms on a yes/no dichotomous scale.
Results suggest that people showing higher acculturative stress scores reported lowered mental health, by way of higher depression and anxiety symptoms, stronger feelings of marginality and alienation and overall poorer adaptation outcomes (Berry, 1992; Dona & Berry, 1994). Other demographic groups that have strongly correlated with high acculturative stress have included women, unemployed people (Nwadiora & McAdoo, 1996), migrants experiencing separation or marginalisation in their new societies (Dona & Berry) and those who spent shorter periods of time in their host countries (Sondregger & Barrett, 2004). It is therefore appropriate to conclude that migrants’ acculturative experiences and acculturative stress is strongly linked to mental health and overall wellbeing.

Although acculturation research is primarily based on migrants’ experiences living in western and developed nations, it is plausible that similar psychological acculturation processes might be prevalent as asylum seekers return to their homelands. In particular, acculturation concerns may well be a factor in the process of resettlement for Southern Sudanese people, who have spent many years living away from their country of origin and are attempting to return to a physical and social environment to which they have not been part of for long periods of time. The acculturation experience of both ‘host’ communities adjusting to the influx of recent returnees and the returnees themselves warrants exploration to determine if or how it may influence the Sudanese’s mental health and subjective wellbeing.

Another consistent predictor of improved acculturation and lowered acculturative stress is social support, where people can gain access to physical and emotional comfort from other people, like their own or supportive families, friends, and other members or services offered within communities (House, 1981). Studies that analyse acculturation patterns of refugee or migrants from developing countries to industrialised countries has repeatedly shown that social support is one of the correlating variables for positive cultural adjustment
(Berry, 1997), and is more likely to bring about the ideal integration and multicultural social environments. Kamya (1997) showed greater integration and mental health amongst African migrants and refugees to the USA when higher social support with both the USA host communities and African communities was arranged for them. Leung (2001) demonstrated that social support was a significant predictor of cultural adaptation amongst Chinese migrants in Australia; moreover, Young’s (2001) research revealed that social support moderated higher levels of self-esteem, life satisfaction and quality of life amongst El Salvadorian refugees in Canada, supporting that acculturation experiences influences the overall wellbeing of migrants. All these studies reported that social support included regular contact with both their host communities as well as other people from their native countries. In contrast, however, Ager, Malcolm, Sadallah and O’May (2002) indicated that social support had both positive and negative impacts on refugees living in Edinburgh. Rather than social support being the main predictor for mental health, time spent living in Europe was a much stronger contributor to positive adjustment. Ager et al. reported that refugees who had been in the UK for over 2 years were twice as likely to report case levels of anxiety and depression as those who had resided for a shorter period. Other studies found that the largest predictors of mental illness amongst refugee population groups were length of time in exile (prior to resettlement), personal experiences of torture and/or near-death experiences, witnessing the deaths of family members and lack of family unity as a result of refugee or migrant status. These trends were similar for Asian and African refugees, including refugees who had sought asylum in other low to middle income countries (Crescenzi et al., 2002; Dyregrov, Gupta, Gjestad & Mukanheli, 2000; Matkin, Nickles, Demos & Demos, 1996; van Ommeren et al., 2002).

Formally resettled southern Sudanese refugees have reported similar social support needs when they have moved to developed nations like Australia. In a study by Schweitzer,
Melville, Steel and Lacherez (2006), perceived social support from within the Sudanese ethnic community predicted improved mental health outcomes of recently resettled refugees. Also, Poppit and Frey (2007) noted that English language proficiency of resettled Sudanese adolescents living in Australia was one of their main stressors and participants reported a desire to increase their language skills in order to better engage in their education systems and with their host community peers. Overall, the literature on migration and on mental health indicate that social support, whether real or perceived, remains an important variable in considering the mental health of refugees and their migration and adaptation experiences. Theories and ideas about how social support functions as protectors for mental health is discussed in later chapters.

Despite knowledge that social support is key to migrant and refugee wellbeing, current migrant research examining social support focuses primarily on the experiences of people having migrated to the west as opposed to those continuing to live in locations that continue to be affected by war and poverty living conditions. Nonetheless, based on the western research, it remains important to consider how the migration experience possibly influences peoples’ capacity to adapt upon returning to homelands following a significant dislocation period. For example, with so many southern Sudanese having moved away from their southern homeland and returning following the nation’s independence, it is important to account for that migratory experience, in addition to understanding how this may or may not have impacted their social support networks, access to basic needs and mental health and wellbeing.

2.5 Refugee psychopathology

Discourse surrounding the influx of refugee psychopathology literature over the past two decades is now extensive. Ingleby (2005) provided a thorough assessment and synopsis of the interests in refugee mental health from an historical and present day perspective in his
edited book, *Forced Migration and Mental Health*. In summary, the main conjecture has surrounded the controversial diagnoses of Posttraumatic Stress Disorder (PTSD) and claims by some authors that all displaced populations experience poor mental health or that the presence of traumatic environments and experiences will always constitute causal concern for the proliferation of mental illness. For example, a study by de Jong, Mulhern, Ford, van der Kam and Kleber. (2000) reported that 99% of Sierra Leone’s population scored so high on the Impact of Events Scale that it was indicative of widespread PTSD.

Humanitarian organisations, like major International Non-Government Organisations (iNGOs) providing material aid to displaced populations, have begun to prioritise mental health programming with an expectation of mental illness as a result of traumatic events, such as the outbreak of political conflict, natural disaster or other causes of forced migration. Wessells (2009) reported that such expectations and contextual insensitivity by well-meaning psychologists working in the humanitarian sector have, historically, caused unintended harm to crisis-affected communities. As a consequence of poor practice, debate was generated regarding the relevancy of western-produced measures for illness and poor ethnographic methodological approaches to research and field-practice. These were referred to as being hazardous, reductionistic or exclusionary of other more pressing concerns for displaced people (Wessells, 2009; Summerfield, 2008). Similarly, conjecture increased within the academic literature about the appropriateness of following a western taxonomy and on what Engel (1977) questioned as being the relevancy of a medical model of illness (Porter, 2007).

Over time, it has been accepted that a straightforward psychopathological perspective of refugee mental health is over-simplified and fails to account for culturally normal responses to extremely abnormal stressors (Kleber, Figley & Gersons, 1995). This approach also does not enlighten iNGOs or other health practitioners about the culturally sensitive and efficacious approaches to intervention and support (Weiss, Saraceno, Saxena & van
Ommeren, 2003). Furthermore, it is now more widely accepted that a range of biopsychosocial dimensions, well beyond traumatic events, contribute to the overall mental health outcomes of displaced populations. For example, little research considers the influences of refugees or IDPs living in pervasive poverty or the impacts of their disrupted social and familial supports. Also, it has been identified that there is an urgent need for further research in the physical contexts of where the refugees or IDPs are living, such as in Africa (Collins et al., 2011), as opposed to simply studying African refugees living in Australia or America.

Despite speculation around the pros and cons of how to ascertain or measure mental health and mental illness amongst displaced populations and people living in developing or conflict-affected countries, the need for such research and understanding about the mental health needs of these population groups remains essential (Collins et al., 2011). Some mental health and mental illness screening instruments have become, over time, considered more valid and efficacious in cross-cultural populations and translated versions. Two measures now used routinely in cross-cultural mental health studies are the Hopkins Symptom Checklist-25 (HSCL-25; Mollica, Wyshak, de Marneffe, Khuon & Lavelle, 1987), which measures symptoms of anxiety and depression, and the Harvard Trauma Questionnaire (HTQ; Mollica et al., 1992), which focuses on symptoms of Posttraumatic Stress Disorder. Both of these screening instruments allow for recording of traumatic experiences, somatic complaints, common symptoms of depression, anxiety and traumatic stress and initial insight to psychosocial functioning. The instruments evolved from the 1980s and beyond and have now been used internationally and validated in a range of languages in Asia and Europe, including Khmer, Vietnamese, Lao, Croatian, Bosnian and Japanese (Mollica, McDonald, Massagli & Silove, 2004).
Various revisions of the HSCL-25 and HTQ have been developed to ensure its continued simplicity and flexibility for translation, including the use of locally and culturally derived terminologies. It has also shown reliability and validity in Africa. Bolton (2001) suggested that ethnographic approaches to implementing the HSCL-25 as a research and screening instrument were highly reliable in the absence of a ‘gold standard’ of cross-cultural methods. Bolton explained that some western measures like the HSCL-25 could still be used and adapted for non-western samples by using local informants and internal reliability (Cronbach’s Alpha) analyses to replace the ideal (or gold standard) of criterion validity testing. With colleagues, Bolton successfully utilised an adapted HSCL-25 instrument as a depression screening tool in Rwanda (Bolton, Neugebauer & Ndgoni, 2002), Uganda (Bolton, Wilk & Ndgoni, 2004) and Kenya (Ndgoni, 2006). However, it is unlikely that issues of psychopathology are the only impacts of displacement. As stated by the World Health Organization (2003, 2004), many other factors contribute to mental wellbeing and vulnerability to mental illness, including poverty and access to social supports.

Porter and Haslam (2005) conducted a meta-analysis to investigate research outcomes of mental health among displaced populations across five decades. They hypothesised that repatriation would be associated with better outcomes on the basis that acculturative stress and dislocation are generally regarded as adverse experiences with negative mental health consequences. Porter and Haslam analysed 59 studies conducted between 1959 and 2002 (median year of publication=1996). They considered studies that included accepted measures of psychopathology, conflict-based contexts and more rigorous studies that engaged control groups that supported comparisons between refugees (or IDPs), returnees and non-refugees. For all groups, findings consistently demonstrated that people with permanent accommodations and greater economic opportunities experienced better mental health outcomes, but people with higher education and pre-conflict material ownership experienced
poorer mental health. This finding clearly suggests that mental health and wellbeing for refugees and IDPs is inextricably linked to the contexts where they live; opportunities for work, access to shelter and basic needs and capacity to meet pre-migration needs.

Porter and Haslam’s (2005) results also revealed another indicator of poorer mental health. They suggested that proximity to existing conflict and exposure to war events were linked with poorer mental health outcomes, but the authors additionally noted that refugee and IDP psychopathology is more far reaching than solely a war or migration experience. Porter and Haslam surmised:

The psychological aftereffects of displacement by war cannot be understood simply as the product of an acute and discrete stressor, but depend crucially on the economic, social and cultural conditions from which refugees are displaced and where refugees are placed (p.611).

One of the most interesting findings in Porter and Haslam’s (2005) meta-analysis was that their hypothesis that the stressors of acculturation might predict poorer mental health outcomes was not supported. The study showed that non-refugee groups (or those who remained in their countries of origin) experienced the worst mental health outcomes, followed by returnees. Refugees or IDPs showed the least amount of reported mental health symptoms. Porter and Haslam suggested two possible explanations. First, that proximity to conflict and war experiences may be influencing the result with non-refugee groups remaining more readily exposed to such events, or second, that more provision of material aid is offered to displaced groups and returnees. As this finding was based on a single acculturative stress scale and other generic quality of life scales in the meta-analysis, Porter and Haslam emphasise the need for replication. It suggests, however, that the migration and acculturative experience alone might not be the best predictors for mental ill-health as opposed to the physical context. For example, in South Sudan, it may be feasible that people
who remained in their homeland throughout the civil war may actually experience worse mental health outcomes than their refugee, IDP or returnee counterparts. It also questions an assumption by many researchers that the majority of mental health attention is needed in the areas of refugee, IDP or returnee care, while those with no significant migration history, who experience just as much, if not more, proximity to conflict and poverty are somewhat neglected.

The Porter and Haslam (2005) study had some limitations. These included the various studies being mixed in their timing of research. Some sample groups were currently experiencing conflict and others surveyed during peacetime, which may have influenced the degree to which proximity to the conflict impacted on mental health. Also problematic was that the various studies used differing measures for psychopathology. Some studies in the meta-analysis gave wider attention to symptomatology than others and there was little consistency of cut-off scores for the many and varied tools used to measure mental health or illness. Another limitation included a skewed sample, with only 2% of the data represented by African studies, which was clearly identified by the researchers as an important region for further investigation. Regardless of these limitations, Porter and Haslam successfully demonstrated positions made by previous theorists (Engel, 1977; Kleber, Figley & Gersons, 1995; Summerfield, 2008) that the psychological impacts of conflict and displacement cannot be simply understood by the traumatic or migratory experiences alone and that there is more to consider than merely the symptoms of trauma-related psychopathology.

Bolton and Betancourt (2004) suggested that a targeted ‘social and material ecology’ approach would be helpful to inform mental health research and practice in conflict settings. This idea was succinctly described by Miller and Rasmussen (2010) in four guiding principles: (1) to always operate from a context analysis that identifies what are the daily stressors for individuals in that developing community, noting that daily stressors may be
social (e.g., social exclusion) or material (e.g., lack of water); (2) attempt to address those daily stressors by a range of programs, which may not be related to mental health interventions; (3) identify individuals who may require specialised mental health care where their distress or symptoms do not abate after practical interventions have been implemented and noticing that treatments may be needed for conditions inclusive of, but not limited to trauma-related concerns; and (4) to acknowledge that some individuals affected by conflict may require mental health support for reasons unrelated to the conflict itself, such as instances of child abuse, domestic violence or complicated grief. By following such phases of mental health intervention, Bolton and Betancourt and Miller and Rasmussen are suggesting that a truly biopsychosocial approach to mental health research and practice, inclusive of the daily stressors, which may include amongst other things the challenges to accessing basic needs, can enable a more truthful perspective of communal mental health needs.

The notion of a social and material ecological perspective of mental health in conflict settings and the theoretical differences between trauma-focused and psychosocial-focused approaches commonly used in humanitarian mental health responses were further explored by Miller and Rasmussen (2010). In doing so, Miller and Rasmussen proposed a theory that supported a reduced emphasis on the impacts of direct war exposure and greater consideration for the critical impacts of poverty, which may or may not have been induced by conflict. Miller and Rasmussen suggested a mediation model where daily stressors, were likely to mediate the relationship of war exposure to mental health. This model is illustrated in Figure 2.

Miller and Rasmussen (2010) suggested that based on the model shown in Figure 2 and a growing body of research to support its assumptions, specialised mental health care may only be necessary for individuals where their emotional or mental health problems do
not subside once those daily stressors or basic needs have been restored (as suggested previously by Bolton and Battencourt, 2004). This model was empirically tested by Jordans, Semrau, Thornicroft and van Ommeren (2012) who studied the role of perceived needs in explaining the association between past traumatic exposures and distress amongst Iraqi refugees living in Jordan and Bhutanese refugees living in Nepal. Jordans et al. found that the perceived needs of the refugees mediated the association between past traumatic exposure and distress. When perceived unmet needs were added to the measures of distress, the significance of past traumatic experiences was no longer directly associated. The authors explain that this finding may be the consequence of war exposure experiences being distal stressors, whereas unmet needs were immediate or proximal stressors, which has been previously shown to impact mental health in a more predictive way than distal life events (Rowlison & Felner, 1988).

*Figure 2. A mediation model of daily stressors as partially mediating the relationship between conflict and mental health (Miller & Rasmussen, 2010)*
For people living in conflict-affected nations, the impact on mental health appears to depend on a multitude of factors. These include: the overall history of individuals pre and post conflict; their migratory experiences; access to survival and basic needs during and post war; economic, social and cultural dimensions from which refugees, IDPs and returnees derive or live. Also, it may not only be people with migration experiences that suffer poor mental health outcomes following conflict. Also vulnerable are the communities who remain in a conflict zone during that time, where they lived in closer proximity to conflict events and had limited access to basic needs. Whether or not a group of people who remain in the conflict zone or those that migrate and return during peacetime are likely to have better mental health outcomes remains to be determined. For example, it is difficult to ascertain in the South Sudan context which group of people might experience better or poorer mental health outcomes – either the people who remained in their homeland during the war (host) or those that fled during the war, experienced refugee or IDP living conditions and are attempting to acculturate back to their native land and tribes (returnees). Research to date is mixed; the host community might be expected to have poorer mental health because they were in closer proximity to the conflict but other research suggests the returnees might have poorer outcomes based on their disrupted social support and acculturative experiences. This thesis aimed to shed light on this question and attempt to ascertain which groups showed greater mental health and wellbeing and what factors – be that access to basic needs, connections with social supports and the migration experience – were strongest in predicting mental health outcomes.
2.6 Implications of cultural perceptions of mental illness for diagnosis and research in developing contexts

Although the ICD-10 (WHO, 2007) emphasises the importance of cultural beliefs and perceptions towards mental illness, it does not present a specific cultural formulation included in the DSM-IV-TR (APA, 2000). According to the DSM-IV-TR’s Cultural Formulation, key variables that influence the presence, diagnoses and severity of mental illness in non-western culture includes etiology, presentation of illness, idioms of distress and treatment options. There is now extensive literature demonstrating that clinicians have found the DSM-IV-TR cultural formulation framework helpful, particularly when working with immigrant or refugee clients living in North America (Lewis-Fernandez & Diaz, 2002; Mezzich, 1995; Segal & Mayadas, 2005; Shaffer & Steiner, 2006; Takeuchi, 2000). This notion is supported by the American Psychological Association’s Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists (as cited in Constantine & Sue, 2003). However, the guidelines also suggest a wider and more encompassing qualitative approach to including cultural responsiveness in the mental health domain.

The American Psychiatric Association (as cited in Constantine & Sue, 2003) guidelines define culture as an embodiment of a worldview, through learned and transmitted beliefs, values, and practices, and which shape the way individuals make meaning of the world. The guidelines emphasise the importance for psychologists to be culturally empathic as a means to better understanding clients’ perspectives of their world, their subjective wellbeing and mental health. Specifically, Choudhuri (2005) focused on the guidelines’ recommendation to using culturally sensitive and centred approaches to psychological research that was inclusive of a cultural lens rooted in the subjective and internal perspectives of individuals. Choudhuri promoted qualitative inquiry as a methodological research
approach that can sufficiently elucidate culturally constructed meanings, perceptions of the world and local perceptions of mental illness.

Using qualitative methodologies in cross-cultural psychology research was advocated by Kramer (2005). Kramer surmised that two common research problems in quantitative methods include making expansive generalisations even though standardised questionnaires often fail to appreciate the experiential world of research participants and that sampling problems abound when people are classified as being part of one culture but not another. In doing so, researchers commonly assume that culture is a categorical variable. However, Ingleby (2005) points out that this is not necessarily accurate as people position themselves in multiple cultures at different times of their lives. Using the southern Sudanese population as a case example, the majority of the people view themselves as belonging to one tribe, but have regular communal contact with other tribes. Some Sudanese may perceive themselves as displaced people, war-affected people, returnees, a host community, an employee versus a subsistence farmer, or any combination of these identities at various points in time.

Despite the DSM-IVs atheoretical basis that purports etiology to be irrelevant to most mental disorders (with few exceptions such as PTSD), research in non-western cultural groups has consistently found that causes of mental illness are a primary consideration and fundamental to treatment intervention (Kaplan, 2009). Vontress (1999) suggests that people in Africa relying on faith healers tended to receive more holistic treatment that met the needs of the individual as well as the needs of their social environment. In Vontress’ qualitative interview with a traditional African healer, a person needing mental health treatment was never compartmentalised according to illness, but the causes of their distress directly informed the most appropriate intervention required. Sometimes this was individual treatment, but at other times, it incorporated a communal approach to care, with people
joining together for special ceremonies or witchcraft procedures to support the ‘cure’ for
certain illnesses.

For the purposes of the present research, it was considered critical that qualitative
approaches formed part of the mixed methods design to ensure meaning could be attributed to
the mental health measures used. It also reiterates the benefits of using a dimensional
approach to measuring mental health, rather than restricted categorical measures of illness.
This offers more freedom to view mental health and ill-health in-context and provides the
sample group with opportunities to attribute their perceptions of causes for mental health and
mental illness.

Another approach to ensure people in the current research were able to contribute in
ways that supported their cultural perceptions was to enable participants to provide
information in their native language. De Jong (2002) has commented on the significance of
local language differences, including cultural metaphors or proverbs as being accepted ways
for people to express emotion or experiences. De Jong suggested that these expressive
disparities and lack of literal translation to DSM-IV-TR (APA, 2000) symptom criteria was
known to lead to diagnostic errors. Malgady and Zayas (2001) supported this assertion
following a quantitative study regarding the challenges of linguistic issues in diagnosis.
Malgady and Zayas showed that presentation and idioms of distress for non-western culture
groups led to significant interpretative differences between clients and clinicians. Their study
observed ubiquitous differences in the construal of illness, misdiagnoses of illnesses and
communication difficulties when exploring the best treatment options.

The need for appropriate cultural diagnosis and exploration of mental illness is even
more pertinent when considering intervention options for those living in developing
countries, such as South Sudan. This is not only due to the limited availability of basic
services, but also in light of customary reliance on traditional or faith healers and community-
based social support approaches. Van de Put and Eisenbruch (2002) identified this as both a pragmatic consideration and an essential link between respecting cultural views of mental distress and culturally accepted ways of curing or managing poor mental health.

Although the DSM-IV-TR (APA, 2000) Cultural Formulation framework and qualitative methods are now well-recognised as best practice to cross-cultural psychological research, a need remains for valid data that is able to scientifically inform mental health practice in the developing context. This also has the potential to inform humanitarian practices as aid workers attempt to fill some of the voids of limited mental health services and programs. For instance, in places like South Sudan, humanitarian organisations may also be able to include mental health and psychosocial support considerations in their existing activities, such as food aid, education activities or economic development programs. To achieve this, some researchers have combined DSM-IV-TR criteria with complementary ethnographic methodologies, such as the use of local informants to help validate western measures and local words or images to illustrate the meanings of psychological concepts (Bolton, Neugebauer & Ndogni, 2002).

In a Rwandan study on the prevalence of depression and anxiety five years after genocide, Bolton, Neugebauer and Ndogni (2002) developed a functional impairment instrument using local assessment criteria. These local criteria were then correlated with DSM-IV criteria for the same disorders to ascertain similarities and differences between local ideas of depression and anxiety and the categorical symptom criteria of the diagnostic manual. This approach was replicated and expanded by Bolton and Tang (2002) who analysed the benefits of ‘free-listing’ to develop community specific questionnaires that were successfully tested for internal reliability and criterion validity. Bolton and Tang suggested this approach could be extended to specific cultures of interest but could be a way to maintain reliable and valid data relevant to both local and western understandings of mental illness and
impairment. This technique was later implemented in Uganda for a controlled trial of psychotherapy interventions for people suffering with local depression-like syndromes (Bass et al., 2006; Bolton et al., 2003).

These studies in Rwanda (Bolton, Neugebauer & Ndogoni, 2002) and Uganda (Bass et al., 2006; Bolton et al., 2003) verified that ethnographic approaches grounded in an exploratory stance and using a combination of quantitative and qualitative measures in local language served as means to potentially filling the gap between western measures, linguistic disparities and an understanding of mental illness and wellbeing across cultures. When also combined with dimensional approaches to measuring mental illness, greater cultural flexibility is further achieved (Alarcon & Foulks, 1995; Thakker & Ward, 1998).

Furthermore, to ensure that cultural perspectives are not discreetly categorised (Ingleby, 2005; Kramer, 2005) and mental illness is merely confirmed or not confirmed (Kleinman, 1977), more information than just mental health data is necessary to truly appreciate any overarching worldviews of those participating in research, ensuring their experiences and cultural traditions are not considered to be secondary in their level of importance (Ingleby, 2005; Kaplan, 2009). For the Southern Sudanese, understanding their perceptions about how they view their level of personal control over their current and future lives will be a fundamental element to research in this study, given their individual and societal experiences of war, displacement and daily struggles for survival. It is likely that such experiences influence their worldview and feelings of hopefulness about the future in addition to how they may realise their mental health and wellbeing. Furthermore, having a sense of personal control and opportunities to optimistically (or hopefully) plan for the future are not only considered intrinsic human rights for quality of life (Universal Declaration of Human Rights, 1948), but are also linked to overall wellbeing (Deci & Ryan, 2008; MacLeod & Conway, 2007; Snyder, 2002; Wichmann, 2011).
2.6.1 Common mental illnesses and their symptoms

Based on prevalence estimates of mental illness throughout all nations in the world, at least one in four families are reported as having at least one member currently suffering a mental or behavioural disorder (WHO, 2001). The World Health Organisation (WHO) asserts that these prevalence figures are inclusive of developing countries like South Sudan. Despite these staggering numbers of people requiring support for mental or behavioural disorders, access to services for mental health needs is estimated to be minimal in poverty affected countries like South Sudan. The WHO (2010) estimates that mental, neurological, behavioural and substance use disorders account for 14% of the world’s global burden of disease and that most people affected – up to 75% in low and middle income countries – do not have access to the treatments they require.

The WHO indicates that of the multitude of mental disorders outlined in the DSM-IV-TR (APA, 2000) and the WHO International Classification of Diseases, Version 10 ([ICD-10], WHO, 2007), those most frequently diagnosed throughout the world are mood and anxiety spectrum disorders, inclusive of PTSD. Though it is recognised that much previous epidemiological research amongst refugee groups or people having lived in countries of conflict has discretely focused on these disorders (Ingleby, 2005), the evidence supports that depression, anxiety, and post-trauma symptoms are the most common mental morbidity amongst these groups (Merali, 2008). Ventevogel, Jordans, Reis & de Jong (2013) identified that locally prescribed syndromes, with close similarities to depression and anxiety disorders have been acknowledged in Africa, including South Sudan.

Mood disorders refer to experiences of mood disturbance, which can be uni or bi polar. According to the DSM-IV-TR (APA, 2000) unipolar depression, with symptoms that are technically referred to as Major Depressive Episode, include symptoms of feeling consistently low in mood and diminished feelings of interest or pleasure in normal activities.
for a two week period. Additional symptoms include weight fluctuations, sleep disturbance, restlessness or irritability, lethargy, feelings of guilt or worthlessness, loss of concentration, indecisiveness and suicidal ideation or behaviour. Such symptoms are broadly consistent with the common construct generally known as depression.

Anxiety has various iterations including specific difficulties with panic, phobias, obsessive-compulsive tendencies and stress. However, more generalised anxiety refers to excessive feelings of anxiety or worry, feeling ‘on edge’, irritable, nervous, physically tense, fatigued, restless, lacking in concentration and sometimes, sleep disturbance or somatic complaints that are persistent more days than not over a period of months (APA, 2000; BeyondBlue, 2013). The other anxiety disorder commonly referred to in the refugee literature is Posttraumatic Stress Disorder (PTSD).

According to the DSM-IV-TR (APA, 2000) the premise of PTSD is that a person has experienced or witnessed an event where they felt threatened with death or serious injury to themselves or to others; and that the threatening event also generates feelings of helplessness and fear. Following this, the three main clusters for diagnosis of PTSD are commonly referred to as Intrusion, Avoidance and Arousal (or Hyperarousal). Intrusion symptoms refer to invasive memories of the event, recurring dreams, or feelings that the event was recurring. Avoidance symptoms generally involve people avoiding stimuli that remind them of the traumatic event and may also include deliberate attempts to escape thoughts and feelings related to the trauma. Other avoidance symptoms can include decreased interest in activities, restricted affect or a sense of hopelessness about the future. The third cluster that identifies PTSD is increased arousal, which can manifest in sleep difficulties, outbursts of anger, poor concentration, hypervigilance or an exaggerated startle response to certain sounds or trauma-related stimuli.
Although the present nomenclature of the DSM suggests that symptoms of depression and anxiety, including PTSD, are primarily heterogeneous (Watson, 2005), the current study utilised these so-called illnesses as a dimensional measure of mental illness and subsequently, as a measure of mental health. As recommended by Watson’s Quantitative Hierarchical Model, the current study perceived mood, anxiety and post-trauma symptoms as a continuum to determine levels of emotional distress. In doing so, a simple paradigm, such as that noted by Keyes (2005) could be ascertained whereby higher levels of depression, anxiety and post-trauma symptoms were suggestive of higher mental illness, while conversely, lower levels of symptoms would be indicative of overall mental health. A dimensional approach for measuring symptoms of mood and anxiety study allows for greater cultural flexibility and enabled ethnographic and qualitative data to fill the gaps between western measures of mental illness and locally perceived determinants of mental health and wellbeing. Kleinman and Cohen (1997) emphasised the importance of such approaches as a means of recognising the value of the vast diversity of symptoms, presentations, etiology and human impact of traditional psychiatric disorders. They further argued that dimensional and qualitative approaches to mental health research needed to avoid the trap of the ‘category fallacy’ (Kleinman, 1977).

The category fallacy refers to previous cross-cultural research that has merely attempted to ‘categorise’ disorders according to an existing criteria (e.g., DSM-IV-TR criteria). In doing so, researchers are prone to seeking out the symptoms that are similar to an existing category of illness rather than grasping the extent or complexity of cultural differences and perceptions of that illness, or mental illness as a societal construct. The current research endeavoured to avoid this categorical fallacy through its mixed methods design.
Based on international knowledge about likely mental health concerns facing the
general population, migratory and war-affected populations, this thesis looked at the
symptoms of depression, anxiety and trauma symptoms as one measure of ill-health.
Acculturative stress was also measured as an indicator of mental health because it has been shown in western nations to influence the wellbeing of displaced and migrant populations. However, as has been repeatedly identified herein, many other factors are likely to contribute to mental health and wellbeing in South Sudan; in particular, the poverty conditions and the Southern Sudanese peoples’ limited access to being able to meet their basic survival needs. Social support is an additional factor likely to influence mental health in South Sudan. The issues of basic needs and social support are further discussed in the following chapter.

2.7 Theories of basic needs

At the most primitive and physiological level human beings require the basics of water, food, safety and shelter from natural or man-made dangers to survive. It has been at this level where many well-known biological scientists throughout history, such as Baptiste de Lamarck, Thomas Malthus and Charles Darwin, have been strongly influential in the development of important psychological theories regarding human instincts, drives, motivations and behaviours (Murphy, 1967). These fundamentals have been recognised as being so critical to life and death that they have for many years been enshrined in International Human Rights Laws adopted by the United Nations (UN) in 1948 stating in Article 3; “Everyone has the right to life, liberty and security of person”.

The concept of basic needs has not merely been described as meeting the basics for survival. Under the culminated Bill of Human Rights, the Covenant on Economic, Social and Cultural Rights (UN, 1966) takes these basic needs concepts further by indicating “the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions” (Article
11). This legal instrument also prescribes that literacy is another human right with States responsible to provide primary education for all and access to education for those who did not receive such opportunities in childhood (Article 13). “The right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (Article 12) is also legally protected by international law.

One of psychology’s most famous theorists that conceptualised basic needs and its contribution to physical and mental health was Abraham Maslow. Driving Maslow’s vision toward a theory of human behaviour and motivation were unanswered questions about how people were stimulated beyond the innate and intrinsic needs to survive to higher values of living that ultimately led to a contentment of their reality – referring to Maslow’s celebrated term, “self-actualisation”\(^4\) (Lowry, 1999). However, underlying Maslow’s motivational theory toward self-actualisation was the assumption that a successive order, dictated by biological urgency and prepotency was necessary before higher motives could be attained (Maslow, 1954). Lowry described this as suggesting that when two motives commanded fulfilment, the more biological and critical motive was intrinsically prioritised while the less prepotent motive was set aside. Maslow (1954) described this saying people would:

… never have the desire to compose music or create mathematical systems, or to adorn our homes if our stomachs were empty most of the time, or if we were continually dying of thirst, or if we were continually threatened by an always impending catastrophe. (p.69)

Whether Maslow referred to survival needs or more abstract needs for love or self-esteem, he maintained that each motivation was ultimately activated by a sense of deficiency. Once those deficiencies had been satisfied, Maslow proposed that a form of growth needs, or

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\(^4\) The term “self-actualisation” was initially founded by Dr Kurt Goldstein in The Organism, 1939, however Maslow’s construal of the concept has become more prominent and widely accepted in the psychological literature (Lowry, 1999 in A.H. Maslow, 1968, p.x).
“metamotivation”, could be reached and in doing so, a level of personal growth toward a state of acceptance, appreciation and enjoyable perception of reality – self-actualisation – could be realised (Maslow, 1968). Based on the hierarchical structure of needs proposed by Maslow and his dichotomous differentiation between deficiency and growth needs, the “Maslow’s hierarchy of needs” model has been depicted in a range of iterations, similar to that shown in Figure 3.

Maslow (1954) described biological and physiological needs literally, as those things necessary for the survival of all living organisms, including humans. In addition to food, water and shelter from the elements, he included sex as a biological need to ensure the survival of the race. Safety needs referred to people requiring basic protection and a sense of security from abuse, exploitation or disease. Following survival and safety, Maslow recognised that humans also needed to belong to a social group and share relational intimacy with others. Maslow stressed that such relationships were essential for optimal child development as well as for the wellbeing of adults. He emphasised that love was an experience to both have and to give to others in a communal human ecology. Maslow surmised that biological and physiological needs, safety needs and belongingness and love needs were fundamental deficiency needs that had to be met for maximum health and wellbeing. Maslow purported that without these basics needs being met, people could not grow cognitively, emotionally and to a point of being able to establish a personal sense of esteem or to achieve the fulfilment of peak experiences or self-actualisation. Ultimately, Maslow’s theory and hierarchy of needs indicated that humans require their deficiency needs to be met before they could grow to higher order concerns and achieve their fullest potential and psychological health.
2.7.1 Basic needs and mental health in humanitarian emergency response

Since the turn of the century, humanitarian agencies working in developed and developing countries alike have encouraged emergency response activities to be first and foremost focused on the delivery of basic needs to population groups affected by disaster or other threats to life and wellbeing, before attending to their more social and psychological needs. Based on international consensus, this approach for ensuring biological, physiological and safety needs as a first line of support is well established. However, the humanitarian sector is now demonstrating that once these survival needs are met, greater acceptance of the psychological impacts of disaster also needs attention (van Ommeren, Saxena & Saraceno, 2005). Similar to Maslow’s hierarchy of needs (Maslow, 1954), the humanitarian responses of today accept that survival needs remain the first priority, but psychosocial support needs are also essential for a holistic emergency intervention and support to affected communities.
This perspective has been sanctioned by international humanitarian standards, such as those established by The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response (2011) as well as the Interagency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007).

The core principles of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007) are grounded in human rights and equity that aim to ensure provision of peoples’ rights to basic survival, economic, social and cultural needs, as per the Bill of Human Rights. It is stressed that provision of such basic needs is essential before any provision of more directed psychosocial or mental health care interventions. This follows the logic of Maslow’s (1954) hierarchy of needs that works on the assumption that if people are unable to meet their most basic and deficiency needs, then supporting communities to higher level considerations, such as working through traumatic experiences, peace building activities or developing group therapy programs becomes irrelevant. The Intervention Pyramid recommended by the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, shown in Figure 4, takes on a familiar prioritisation for meeting peoples’ mental health needs through the supply of basic needs. However, unlike Maslow’s hierarchy of needs, The Intervention Pyramid is not considered stepwise. It suggests that in any humanitarian emergency response, different people will require different types of support, but the foundation of the pyramid indicates that all people need basic services and security needs as a minimum.
The IASC Guidelines on Mental Health and Psychosocial Support (IASC, 2007) intervention pyramid describes the four psychosocial support levels as follows:

*Basic services and security* such as ensuring peoples’ access services like primary health care, legal assistance, shelter, safety, water and the like. The guidelines suggest that many people will return to their normal psychosocial and mental state, once these basic needs are restored.

*Community and family supports* involve a smaller number of people who will need additional assistance to re-connect with their normal family communal social supports. In a humanitarian context this might include family-tracing services, children’s group activities or adult livelihood groups.

*Focused, non-specialised supports* are intended for people affected by crises who might need slightly more assistance to restore their psychosocial wellbeing, such as by
receiving psychological first aid, support from primary health care staff or being part of
groups that aim to directly improve feelings of wellbeing.

Specialised services are usually required for only a small number of people
affected by crises, such as people requiring specific psychological or psychiatric support;
particularly people who had pre-existing mental health conditions prior to a humanitarian
crisis.

One of the concerns regarding the IASC Guidelines on Mental Health and
Psychosocial Support in Emergency Settings (IASC, 2007), from which the Intervention
Pyramid for providing mental health and psychosocial support in emergencies derives, is that
it has little empirical support. This is despite the guidelines following a logical ideal and
drawing from a body of evidence-informed data (Hobfoll et al., 2007). Wessells and van
Ommeren (2008) acknowledged that the guidelines evolved through an extensive process of
international consensus, flagging potentially harmful practices and promoting rights-based
and inclusive approaches to provision of mental health and psychosocial services in the
humanitarian and emergency response sector, but systematically researched data remains a
gap. Specifically, to determine whether or not the fundamental provision of basic needs,
services and security independently promote improved mental health and wellbeing in
humanitarian contexts, and further to Maslow’s (1954) theory, whether basic needs, safety
and social support independently can contribute to mental health and wellbeing.

2.7.2 Basic needs as a discrete measure to ascertain its association with mental health

This thesis aimed to explore the relationship of basic needs and social support to
mental health and wellbeing. These aims are grounded in Maslow’s (1954) theory for basic
needs being essential for optimal health and the principles of the IASC Guidelines on Mental
Health and Psychosocial in Emergency Settings (IASC, 2007). Empirically validating a
complete international guideline like the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007), or the long-standing and well-accepted premise of Maslow’s hierarchy of needs would be overambitious for the current study. Nevertheless, the research expected to demonstrate that at the most base level, having access to basic needs and community social support are likely to be significant contributors to mental health; and to emphasise the importance of such variables for consideration in continued mental health research in developing countries. In view of the links between Maslow’s theory and hierarchy of needs forming the underlying premise of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, the variable of basic needs was used in this study to define and further research its influence on mental health. The South Sudan context was used as an archetypal environment where basic needs and poverty are persistent and pervasive, and where people have experienced the protracted humanitarian crisis of civil conflict.

In developing countries where poverty is omnipresent, such as post-emergency/post-war South Sudan, the link between poverty itself and psychological wellbeing has been described as cyclic (WHO, 2001). For example, a farmer and head of household in South Sudan may have been forced to move with their family to another region of the country to ensure their safety during the war. In doing so, s/he has lost access to their livelihood and their ability to provide the basic needs required for her/himself, and their children. Feeling isolated from their normal social supports, disempowered and highly stressed by this situation, s/he is at greater risk of experiencing mental illness and its related symptoms, which in turn prevents them from finding work in their new location. Meanwhile, because of war and low productivity of the general population, like this farmer, the State is unable to provide any forms of welfare or other financial support to individuals or families. This farmer is no longer contributing to the economic viability of their nation and remains in
perpetual poverty until somebody in their family or the State is in an improved position to help to meet their basic needs.

In more technical terms, the World Health Organization (2001) has observed that conditions of poverty have the potential to further exacerbate mental illness; the micro or individual impacts of poverty and lack of basic needs may lead to higher prevalence and greater severity of mental and behavioural disorders, which consequently leads to a macro or societal impact on a developing nation, where people are less able to contribute economically and to meet their own needs. This in turn affects a nation’s capacity to provide adequate care for their people and it is forced to increase local costs, subsequently cycling back to pervasive poverty impacting the majority of the population. This cycle of poverty, mental disorder and economic impacts is depicted in Figure 5.

Overall, basic needs seem to be more than simply the ‘survival needs’ of the human race. It is suggested that basic needs are inherently linked to psychosocial wellbeing, including in poverty and humanitarian situations (IASC, 2007; WHO, 2001). Basic needs include more than just food, water and shelter. Based on the IASC Mental Health and Psychosocial Support Guidelines in Emergency Settings, they can also include assurance of physical safety and protection as well as safety of mental wellbeing (e.g., freedom from factors that may contribute to mental illness), livelihoods, social support or other opportunities to lead a quality life. Quality of life is a broad term, but for the purposes of this research, it also incorporates a sense of being socially included, having meaningful relationships with others and being socially supported, having personal control and a sense of hopefulness about the future.
Figure 5. The links and cycles of poverty and mental illness, adapted from World Health Organization (2001).

According to International Human Rights Laws and minimum standards for humanitarian emergency response (Sphere Project, 2011; IASC, 2007) basic needs include a range of factors, with a range of potential consequences when they are met or are not met. International Human Rights Laws suggest that the ability of individuals to meet their own basic needs is linked to peoples’ rights to life with dignity. Minimum standards for humanitarian response indicate that improved access to basic needs and safety/security will better ensure peoples’ overall wellbeing and their capacity to cope well in their adverse situations and feel a sense of hope about their futures.

Although it is recognised that basic needs are linked to many constructs and factors, for the purposes of the current study, basic needs incorporate the following fundamentals viewed as essential for survival: food, water, shelter, safety, educational attainment, medical care and livelihood (including employment) opportunities. Even though some analysts suggest that family or community social support also constitutes a basic need, since it is
incorporated as one of Maslow’s primary deficiency needs (1954), this study investigated social support as a separate and discrete variable.

2.8 Social support and mental health

The construct of social support has been defined in various ways in the psychology literature. Cobb (1976) described social support as the personal belief that one feels cared for, loved, esteemed and valued by others and belongs to a network of communication and mutual obligations. House (1981) extended this definition by identifying four main categories of social support. These categories included (1) emotional support usually received from family and close friends; (2) appraisal support incorporating the exchange of information through affirmation, feedback and social comparison; (3) informational support like receiving of advice, suggestions or directives aimed to help others problem-solve; and (4) instrumental support, such as material aid and in-time assistance. House established that various forms of support from some or all of the four categories were provided primarily by family and close friends. However, according to House, some support was also feasible at the employer, co-worker or community levels, particularly appraisal support and self-evaluation. Social support can therefore be deemed a broad construct that includes the physical and emotional comfort provided by our family, friends, and others, with individuals believing they are part of a community of people who love and care for them, value them, and think well of them.

Social support has long been an important consideration for psychologists as it is well established that social support has many advantages to wellbeing. Conclusive evidence in developed nations has determined that individuals with family and other social supports experience reduced negative effects of stressful life events, greater opportunity for physical and psychological health and more efficacious coping in adversity (Pearlin & Schooler, 1978; Sarason, Sarason & Gurung, 1997). The influences of physical (biological), mental
(psychological) and social wellbeing lends support to a true biopsychosocial model of physical and mental health (Engel, 1977) as a more holistic approach to perceiving mental health and overall wellbeing.

Research has attempted to understand the strong link of social support to improved health and mental health outcomes. Cohen and Hoberman (1983) considered whether the positive association is attributable to benefits of social support during non-stressful as well as stressful experiences. This has been called the ‘main effects hypothesis’. Additionally, Cohen and Hoberman tested the positive association of social support and wellbeing to a ‘buffering hypothesis’ whereby the physical and mental health benefits of social supports might only occur during times of high stress and thus protect individuals from poor physical or mental ill-health as a consequence of that stress. In simple terms, Cohen and Hoberman tested whether or not people who feel supported by others feel less stress in general (main effects hypothesis) or whether people who feel supported by others only feel less stress during high-stress periods (buffering hypothesis). The results showed that less stress was experienced by people who felt they had ongoing social support, as well as by those who had access to support during difficult times. Thus, the research demonstrated support for both the main effects and the buffering hypotheses. In summary, research shows that social support functions as a biopsychosocial influence that lowers the likelihood of physical illness, reduces psychological distress during stressful periods and expedites recovery from both physical and mental illness (Broman, 1993; House, Landis & Umberson, 1998).
2.8.1 Social support as an asset in developing contexts and amongst migrant groups

The role of social support in developing nations is just as critical, if not more so, than that observed in western research. International development programs that aim to find sustainable assistance for people living in poverty use a common sociological term known as ‘social capital’. Social capital refers to more than the biopsychosocial effects of social support. Social capital not only relates to the contributions of physical, mental and social wellbeing, but adds that such support is also an asset (i.e., a ‘capital’) with the potential to enhance productivity and economic gain (Burt, 1997). Pennar (1997) suggested that social capital is a “web of social relationships that influences individual behaviour and thereby affects economic growth”.

Social capital has been found to have positive mental health outcomes, which implies that while social capital has economic benefits, it is also likely to have emotional and wellbeing benefits too. Woolcock (1998) observed that increased social capital was positively correlated with greater social inclusion, higher education outcomes, lowered crime and improved work opportunities. Thus, people with improved social support and social capital also experience greater access to life opportunities, such as employment, and therefore improved mental health. However, the direction of causality and correlation between social capital and social support more broadly is yet to be fully determined given this is a relatively new research domain (Lochner, Kawachi & Kennedy 1999). Nonetheless it remains evident that social support may also translate to more practical social capital, particularly in low and middle income countries where social networks form a critical piece of being able to realise even small scale, local opportunities, such as access to employment, education or general social inclusion and other forms of social support.

Rahim and Cederbald (1989) observed that the experience of migration might adversely influence access to social support and thus social capital, on the basis that
individuals and families have removed themselves from what was previously a communal social and support structure. Rahim and Cederbald studied a group of young adults in northern Sudan, where those who had migrated from rural to urban regions showed more symptoms of common mental disorders (e.g., depression and anxiety) than other youth who had been raised in the urban environment. The study established that loneliness was widespread amongst migrated urban youth, suggesting the impacts of migration and isolation from their previous rural families and communities were contributing to poor mental health.

Although a direct link between a lack of social support, poor mental health and a lack of social capital is still tenuous in the research, it follows that in developing countries, people with fewer social supports might also have reduced access to social capital opportunities, including economic development and access to basic needs. This might be the situation for people whose social support structure is disrupted following migration and their return to homelands, as has been the experience of many southern Sudanese people (returnees). Social support may contribute both to access to basic survival needs, including through employment or housing opportunities, as well as physical and mental wellbeing. Interestingly though, research has also recognised that whether this type of social support is actually real and readily available to people may only be part of the picture.

2.8.2 Real and perceived social support

In the same decade that the concept of social support gained popularity in the mental health literature, another important and conclusive finding was revealed, adding to the modern-day definitions of social support. It was recognised that social support could be real or perceived (Barrera, 1986).

Incorporating the idea of real and perceived social support, Hofboll (1988) determined that social support consisted of social interactions or relationships that provided individuals with actual assistance (real social support); or that those interactions existed within a social
system where individuals believed they could be provided with love, nurturance or a sense of belonging to a particular social group (perceived social support). One of the fundamental distinctions provided in this definition is that of actual assistance versus believed or perceived assistance. In South Sudan, it is possible that both real and perceived social support play a vital role in peoples’ wellbeing. For instance, the Sudanese are known to feel a strong sense of loyalty, belongingness and connectedness to a tribe, and this perceived social support is considered vital regardless of whether or not they receive practical support to helping each other meet their basic needs (Rahim & Cederblad, 1989).

In a more recent meta-analysis study of real and perceived social support, Haber, Cohen, Lucas and Baltes (2007) confirmed that perceived social support appears to have greater influence on positive outcomes for most researched variables of health (e.g., physical health, mental health, positive outlook). Yet, despite statistically significant effect sizes that indicated perceived social support was a stronger predictor of mental health, only 10 to 20 per cent of the variation was explained by the link between social support and wellbeing. Haber, Cohen, Lucas and Baltes (2007) suggested that other factors were likely to be playing a role in perceived social support being a predictor of health, such as individuals’ environment or ecology, their perceptions of whether or not that environment was generally supportive and meeting their needs (including real social support) as well as the explicitness of a support network that people could discretely identify. These factors were considered potentially influential on individuals’ perceptions of social support. Based on Haber et al.’s research findings, it is possible that people living in wealthy nations might be more inclined to easily recognise their social supports, as opposed to those living in poverty conditions like South Sudan, where the adversity of the surrounding environment might overwhelm perceptions of having adequate social support to help them meet their essential needs. Therefore, the notion of perceived social support in a South Sudan context might be less recognisable to individuals
or families given they may feel more besieged by the daily struggles of living in poverty. Conversely, the Sudanese culture may still perceive social support strongly based on their traditional belief-systems that strongly attribute importance to tribal affiliations. Ultimately, the expected findings of whether perceived or real social support will be more prominent as predictors of mental health in South Sudan are difficult to determine and warrants exploration.

Procidano and Heller (1983) ascertained that perceived social support could be viewed as two separate but related paradigms; perceived social support from family and perceived social support from friends. They reported that perceived social support from both family and friends resulted in fewer symptoms of distress and psychopathology, but the relationship was significantly stronger when there was greater perceived family support. In contrast, perceived social support from friends was related to higher social competence, capacity to utilise relationships in a beneficial way, and lower anxiety. Hence, while perceived support from family and friends are both important components of individual wellbeing, the benefits of social support from either family or friends differed. Implications of these findings suggest that familial connections are vital to mental health and a sense of belonging, while communal and peer relationships might be more practical in converting social support to protecting individuals from real-life stressors, such as unemployment or meeting basic needs.

Although it is evident that real and perceived social support from family and friends are key contributors to overall health and wellbeing, the actual process of how this transpires has been another investigative theme throughout the social support literature. Cohen and Hoberman’s (1983) direct effects hypothesis and buffering hypothesis (outlined above) is one potential model for mapping the processes of social support and wellbeing. Norris and
Kaniasty (1996) proposed an alternative mediation model however, which has received growing acceptance in the social support field (Hobfoll et al., 2007).

Norris and Kaniasty’s (1996) Social Support Deterioration Deterrence Model noted that while social support assists people during high times of psychological distress, loss of more structured supports, such as social services, community infrastructure and health services are often depleted at the same time. This is especially the case post-crisis, such as following a hurricane or other disaster. As a result of these social support losses, people tend to reach out for social support, and often receive them from alternative service-providers (e.g. humanitarian actors) or others in the disaster-affected community, and thus their perceived social supports become re-engaged. As Hobfoll et al. (2007) stipulate, this phenomenon and requisite for social support is no more evident than in developing countries. This is particularly the case for those who have experienced disaster or mass trauma where people become especially vulnerable in the absence of real and systematised assistance. Social support, from family as well as communal friendships, can provide direct assistance by way of information (e.g., “where can I get food?”), tangible assistance (e.g., “you can sleep in our home”) as well as non-directive supports (e.g., social comparison with others) and encouraging social interactions that assist in positive coping strategies and lowering of potential psychopathology (Barrera & Ainlay, 1983; Pearlin & Schooler, 1978; Procidano & Heller, 1983). Even if the perceived support provided from family and friends is lesser than that actually received, the mental health benefits are likely to be upheld (Hobfoll et al.; Norris & Kaniasty; Procidano & Heller).

In summary, given that perceived social support plays such a functional and critical role in helping people to access existing, new or potential resources, it is logical that perceived social support might also play a role in helping people gain access to their basic needs and to utilise the social capital of those social networks. Therefore, social support
warrants discrete treatment as a variable and exploration on whether it mediates access to basic needs and subsequently contributes to mental health in South Sudan. While these effects have been frequently demonstrated in studies based in developed nations, they may be an even higher priority in developing countries and amongst displaced communities, where social support from extended family structures, religion and village life plays a substantial role in non-western cultures like South Sudan. Additionally, as shown in western-based refugee studies, the capacity for people to access social support and thus access to basic needs may be further complicated by their capacity to positively acculturate to their new and dominant societies (Berry, 1992), such as the homeland for returning southern Sudanese families.
CHAPTER 3: AIMS OF THE PRESENT RESEARCH

In view of the lack of psychological research based in developing countries, this thesis sought to better understand mental health and wellbeing in Africa’s newest nation, South Sudan, where pervasive poverty, conflict and lack of basic needs impact the majority of its population. It aimed to explore the similarities and differences between people who remained in South Sudan throughout the civil war, known in this study as the host sample group, and those who had recently returned to their homeland following a displacement and migration experience, known in this study as the returnee sample group.

Two studies were conducted concurrently, which employed quantitative and qualitative methodology. The first quantitative study considered the influences of basic needs and social support on mental health, and explored how the migration experience of recent returnees might have hindered or enhanced their mental health. The second qualitative study sought to enhance understanding about the causes and presentations of mental illness in the distinct culture and context of South Sudan. The qualitative data was also used to explore whether the host and returnee sample groups had a sense of control over their present situation and how they perceived their futures. As a guide, Figure 6 provides an outline of the format and flow for the research, beginning with the research overview, literature analyses and research aims, and the subsequent presentation of the two concurrent studies and how they are reported and discussed.
3.1 Analysis of influences on mental health in South Sudan: Quantitative research hypotheses

The first study’s hypotheses analysed the total sample group (host group plus returnee group) to ascertain overall contributors to mental health in South Sudan. Following this, the research explored the prospective different mental health outcomes between the host and returnee groups and whether the strength of the influences of basic needs, social support and acculturative stress differed between these two groups. The construct of higher mental health outcomes was represented by fewer symptoms of depression, anxiety, PTSD and acculturative stress, measured as a continuum of symptoms.

3.1.1 Hypotheses Set 1

Based on Maslow’s (1971) Hierarchy of Needs model and the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007) it was
hypothesised that for the total sample (host plus returnee sample groups), greater access to basic needs, higher perceived social support, and low acculturative stress would be associated with higher mental health outcomes. It was further predicted that greater access to basic needs would be the strongest predictor of higher mental health outcomes, followed by higher perceived social support. In light of the poverty-stricken context of south Sudan, it was expected that low acculturative stress, in comparison with basic needs and social support, would only minimally contribute to mental health. The predicted outcomes for hypothesis one is depicted in Figure 7, showing the anticipated relationship of the influences of basic needs, perceived social support and acculturative stress on mental health, with numbers reflecting the expected order of the strength of relationship that each of those influences would have on mental health.

![Diagram](image)

**Figure 7.** Hypothesis of the relationship between basic needs, perceived social support and acculturative stress and mental health; and the order of the expected strengths of each variable.

Represented in Figure 8, the study further examined how basic needs and social support influenced mental health. It was expected that in South Sudan’s post-war and poverty context, social support would be critical and related to basic needs (Hobfoll et al.,
It was also expected that social support would act as a vital contribution to an individual’s social capital, demonstrated by a direct relationship between social support and mental health being mediated by greater access to basic needs. In other words, it was hypothesised that social support would lead directly to higher mental health outcomes because it also leads to greater access to basic needs. This mediation hypothesis is shown in Figure 8.

Figure 8. Expected outcome for the total sample group that the relationship of higher social support and higher mental health outcomes would be mediated by greater access to basic needs.

3.1.2 Hypothesis Set 2

The second set of hypotheses focused on an examination of whether or not differences in mental health and its influences would exist between the host and returnee sample groups. As indicated in the literature review, it remains uncertain as to whether or not a migratory sample group or those who remained closer to the conflict would experience stronger mental health outcomes. Despite Porter and Haslam (2005) reporting that closer proximity to conflict and host groups often have less access to material aid/basic needs, which led to lower
mental health, the current study expected a contrasting outcome. Since the host sample group would not be attempting to reintegrate to their homeland like the returnees, they would therefore have few or no symptoms of acculturative stress, a more sustained social support network and ultimately greater access to basic needs; all of which were hypothesised to result in higher mental health than their returnee counterparts.

It was further expected that the strength of the influences of basic needs, social support and acculturative stress would differ between the host and returnee groups. Specifically, it was expected that the host group would have higher access to basic needs and social support than the returnee group, but acculturative stress would only be influential on the mental health of the returnee group. Moreover, it was hypothesised that host or returnee status would moderate the influences of basic needs, social support and acculturative stress on mental health. This moderation of host or returnee status is depicted in Figure 9.

\[\text{↑ Basic Needs} \quad \downarrow \text{Acculturative Stress} \quad \rightarrow \downarrow \text{Mental Health} \quad \rightarrow \uparrow \text{Social Support} \quad \rightarrow \uparrow \text{Mental Health} \]

\text{Host/Returnee status moderates the strength of the influences of basic needs, social support and acculturative stress}

\text{Figure 9. Hypothesis for the strength of the influences of basic needs, social support and acculturative stress on mental health, moderated by host or returnee status}
Based on the moderation model, it was predicted that for both the host and returnee sample groups, basic needs would remain the strongest predictor of positive mental health outcomes. However, it was expected that for the host sample group, social support would be a stronger predictor of mental health, but for the returnee group, low acculturative stress would be more strongly linked to mental health outcomes than social support.

3.2 The subjective impressions of mental illness in South Sudan: Qualitative research questions

To allow for the qualitative data to inform the research and ensure genuine cultural themes could emerge, there were no pre-conceived hypotheses in this second study. Rather, open research questions guided the subjective exploration to mental illness within the sample groups and their cultural context. Though the qualitative study sought to explore slightly different issues to the first quantitative study, the concurrent studies complemented each other from their perspectives of considering influences of mental health and mental illness.

The following were the targeted research questions of the second study:

- What are the social structures of the community? This question was analysed in relation to how social order influenced social support from families and friends.
- In the participants’ eyes, is the current state of poverty in South Sudan a greater need than mental health concerns or the traumatic experiences from the war; and how do people in South Sudan associate their access to basic needs and social support with mental health?
- What do people in South Sudan perceive as the causes, symptoms and treatment options for mental illness; and how do their communities respond to those with mental illness?
- Do participants view themselves as having some autonomic control in their lives; and
• How do participants view their short term and long term futures and is this influenced by their current situation?

To address these research questions, a semi-structured interview was devised, based on Bolton’s (2001) prior ethnographic study about the community in general, and questions based on the DSM-IV-TR (APA, 2000) Cultural Formulation. These were expected to reveal greater depth about how people in South Sudan perceived their cultural identity, social connections, problems in their communities and issues related to mental illness. In particular, the research sought to answer whether or not the participants’ current situation of poverty and deprivation were, in their eyes, a greater need than mental health concerns or the experiences of trauma from the war. Also, the qualitative research aimed to answer how people in South Sudan associated (or did not associate) their lack of basic needs and social support with their mental wellbeing. Furthermore, the qualitative study examined how well the participants viewed their sense of control in their current situation and their views of the future. Finally, through analysis of the qualitative data, potential differences of experiences, perceptions and hopes about the future between the host and returnee groups was explored.
CHAPTER 4: RESEARCH METHOD

This chapter provides details of the implementation of the two concurrent studies. It begins with a description of the participants, including their demographic information by gender and group, as well as an overview of their access to basic needs to help depict the unique Sudanese context where the participants lived and the context in which the study was conducted. Following this, an outline of the overall research procedure is provided, including a description of the research interview schedule. This concludes the research method chapters, but some of the finer procedural details for each study are presented separately in the subsequent chapters. To recap, study one focused on quantitative analyses of influences on mental health in South Sudan, and study two looked at the qualitative impressions of mental illness in South Sudan.

4.1 Participants

The total sample comprised 53 adults presently living in and around the Malakal township of the Upper Nile state in South Sudan. Participants were selected through a Community Mobiliser who was an employee of a well-known International Non-Government Organisation (iNGO) working in the region – World Vision South Sudan. The Community Mobiliser was a local resident employed for outreach activities aimed to encourage community members to become involved in local programs and services, such as those provided by iNGOs. Information about the research was also announced at a local church service where some people volunteered their participation. Following this, additional participants were recruited via snowballing within communities and through the Community Mobiliser (the number of participants recruited via the different approaches was not documented).
Participant selection criteria was kept broad to enable greater involvement of adult participants, 50% of which needed to be male and female in each of the two groups – people who had remained in south Sudan throughout the civil war (host group) and those who had lived outside of the south but had returned within the previous two years (returnee group). Participants only took part in the study if they were willing to do so voluntarily and without pay.

Finally, the translator who was briefly employed for the research project provided the study with additional qualitative data as a key informant for Study 2. Key informants are commonly used in qualitative research to offer researchers primary sources of information and customary perceptions in the field context where the research is being implemented (Taylor & Bogdan, 1998; Bryman, 2004). The key informant was not included as a participant in the first study, which focused only on the direct participants’ quantitative data.

During the key informant interview, lasting 3 hours and held over two sessions, data from the key informant enabled the research to clarify some of the local customs and nuances referred to during the qualitative data collection. For example, clarity was sought about wife-inheritance laws, traditional gender roles, the actions of witchdoctors and how people use these treatments for mental disorders. Some translations were also discussed in greater depth as common terms emerged throughout the qualitative (Study 2) data collection process. The key informant was a respected local [Christian] church elder who may have presented with some religious bias in how he described traditional or animistic practices. The key informant may have also been influenced by participants’ responses, which were provided prior to the key informant interview. However, because the qualitative data collected from the key informant sought only clarification and explanation of already presented data, it was not considered problematic for the qualitative analysis and was only utilised to illuminate the information provided by the respondents.
The majority of participants were able to confidently report their ages, however, 9.43% \((n=5)\) estimated their age due to lack of knowledge regarding their official age or birth dates. Overall, participants were aged between 20 years and 50 years \((M=33.67, SD=8.01\) years). Twenty-seven participants were men aged between 22 years and 50 years \((M=34.29, SD=8.48\) years) and 26 participants were women aged between 20 years and 50 years \((M=33.07, SD=7.61\) years).

The host group of 26 Sudanese nationals who never left South Sudan during the civil war consisted of 13 men and 13 women with an average age of 31.53 years \((SD=8.21\) years). The returnee group of 27 Sudanese nationals who had left the South Sudan borders during the civil war consisted of 14 men and 13 women with an average of 35.77 years \((SD=7.37\) years). In the returnee group, the length of time participants estimated they had been displaced ranged from 11 years to 25 years \((M=17.40, SD=3.51\) years) while the amount of time they had spent back in their homeland of South Sudan ranged from 1 month to 84 months, with the average time returned being less than two years \((M=22.09, SD=19.25\) months). The majority of returnees had sought asylum in the north of Sudan, particularly in Khartoum with only two participants having reportedly returned from asylum from Ethiopia. Despite most returnees being formally classified as “internally displaced persons” because they remained in the Sudan borders, the cultural differences, refugee conditions and stressors, and now independence between north and South Sudan are all indicative of the research participants having had a refugee experience.

Marital status of the host and returnee groups was varied, as percentages show in Table 1. In total, the majority of both groups were in a marital relationship \((69.8\%, n=37)\), others reported being unmarried, widowed, separated from their partners or inherited. Separated couples referred to those who were not presently living with their husband or wife, which may have been due to marital difficulties, but more commonly due to continued family
displacement. This is demonstrated by more of the returnee group participants reporting separation than the host, suggesting that many returnee’s husbands or wives remained displaced. Inherited couples referred to husbands who inherited one or more wives from brothers or other male family members, or refer to wives who were officially married according to inheritance laws. Local inheritance laws stipulate that when a husband dies, his wife is automatically inherited by his brother, brother-in-law or nearest male relative. Interestingly, wife-inheritance was a traditional practice only reported by the Sudanese in the host group (see Table 1).

Table 1

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Host Group (%)</th>
<th>Returnee Group (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=27)</td>
<td>(n=26)</td>
</tr>
<tr>
<td>Married</td>
<td>69.2</td>
<td>70.4</td>
</tr>
<tr>
<td>Not Married</td>
<td>7.7</td>
<td>7.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>3.8</td>
<td>7.4</td>
</tr>
<tr>
<td>Inherited</td>
<td>11.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Separated</td>
<td>7.7</td>
<td>14.8</td>
</tr>
</tbody>
</table>

Note. N=53. “Inherited” refers to relationships that were resultant of traditional practices where husbands “inherit” one or more wives from brothers or other male family members who had died.

Most participants reported having children, with only three in the host group and two in the returnee group being childless. The number of children was similar for participants in both groups ranging from one to nine. The participants’ youngest children’s ages ranged
from a few months to 14 years of age. The ages of their eldest children ranged from a few months (where participants had only one child) to 25 years of age; but on average older children were not of working age (\(M=10.32, SD=7.74\) years). Working age in South Sudan is highly variable, with many young children forced to work to support family needs; however, the socially accepted ‘working age’ would be children who have completed primary level education, which would indicate approximately 12-14 years of age. In the current sample, adult participants with school-age children reported that 91.42% of those children were enrolled and attending school.

In relation to the participants’ access to basic needs, including food, water, shelter, safety and access to education, medical care and livelihood opportunities (including paid employment) the host and returnee sample groups differed in their experiences, as did men and women. Given the signing of peace accords and the relatively large size of the Malakal township where participants lived in or near, they all experienced relative safety, with exception of infrequent skirmishes. Analysis of the differences in the host and returnees’ access to basic needs is presented in the Results section of Study 1 where the links of basic needs and mental health and well-being are further examined. However, based on demographic data collected verbally during participant interviews (refer to Appendix B for interview schedule), an outline of this demographic information follows to demonstrate how well these two groups had access to basic needs.

The host and returnee groups each reported having access to less than two meals per day (host meals per day; \(M=1.85, SD=0.37\); returnee meals per day; \(M=1.87, SD=0.34\)). Similar levels of access to meals per day were reported between men and women (men meals per day; \(M=1.83, SD=0.38\); women meals per day; \(M=1.88, SD=0.33\)). When participants were asked if they commonly experienced hunger, 81% of men reported yes, compared with 73% of women.
Since all participants involved in the study lived in or near the main township of Malakal, access to water was quite high. Yet, this did not necessarily relate to having access to a clean and safe water source. Returnees had more access to [unclean] town tap water at a rate of 48% compared with 38% of their host participant counterparts. River water, from the nearby White Nile River, was the main water source for 42% of people in the host group and 25% of the returnees. In both groups, just over 11% had regular access to a verified clean water source.

In post-war South Sudan, paid employment or livelihood opportunities was reported in various forms. It referred to being a paid staff member by a regular employee, short-term contract work, and day to day work such as in the construction sector or undertaking odd jobs for money, such as women selling crafts. Some examples of responses by participants indicating their main sources of family income included:

*She is a cleaner. In the hospital. (Host 3 - ID30 – Female)*

*He’s not working. He’s a student. He’s working at the daily work. He can drive the boat sometimes. (Host 19 - ID46 - Male)*

*So he [she] used to make a beads, she is wearing, and the work which she has done before, handwork. (Returnee 6 - ID6 – Female)*

*He’s a government official. (Returnee 11 - ID11 – Male)*

A summary of the employment data revealed that gender did not appear to influence participants’ employment and work opportunities, showing that both men (37%) and women (35%) had almost equal access to steady employment. However, participants in the host sample group reported higher steady employment status at 42% in comparison to their returnee counterparts who reported less than 30% access to steady employment.

Despite lower levels of regular income and steady employment, returnees described having better housing, with 44% living in solid buildings made of brick or wood and an
average of 2 rooms per home ($M=2.12$, $SD=0.82$). The majority of the host sample group described living in more traditional Sudanese housing structures made of mud and grass, known as Rukabas, also with an average of two rooms (or two Rukabas) per home ($M=1.92$, $SD=0.81$). Even though the host communities lived in poorer quality homes, they tended to accommodate more people with an average of nine people per home ($M=9.08$, $SD=4.98$) while returnees had an average of seven people per home ($M=6.96$, $SD=3.41$).

Most people involved in the study had minimal access to health services. The town hospital located in the heart of Malakal was equally accessible to 23% of host and returnee participants. However, the vast majority did not have access to a local health clinic for simple and regular health services with 65% of host participants reporting no health services and 52% of returnees reporting the same.

Participant education levels varied between host and returnee groups as well as by gender. Twenty percent of the total sample had no education at all, with the host group reporting less formal education than the returnee group. Only 31% of the host sample group had completed secondary education compared to 44% of the returnee group. Similarly, returnees had higher post-secondary education at nearly 15% of the total sample compared with 11% of the host group. Consistent with the South Sudan context analysis that examined gender roles (refer to Chapter 1.6, p.13), the current study reported that men had obtained higher levels of education than women. Thirty-four percent of women in the total sample had received no education at all, while 44% of men completed secondary school compared with just 27% of women. A full breakdown of education levels completed in the sample is provided in Table 2.
Table 2

*Percentage of completed education levels of total sample by gender and by group.*

<table>
<thead>
<tr>
<th>Completed level of education</th>
<th>Host sample group</th>
<th>Returnee sample group</th>
<th>Total sample group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men (n=13)</td>
<td>Women (n=13)</td>
<td>Total (n=26)</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>No Education</td>
<td>7.69</td>
<td>38.46</td>
<td>23.08</td>
</tr>
<tr>
<td>Early Primary (Yr 1-4)</td>
<td>7.69</td>
<td>15.38</td>
<td>11.54</td>
</tr>
<tr>
<td>Late Primary (Yr 5-8)</td>
<td>23.08</td>
<td>23.08</td>
<td>23.08</td>
</tr>
<tr>
<td>Total Primary Level</td>
<td>30.77</td>
<td>38.46</td>
<td>34.62</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Secondary Year 1</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>7.69</td>
<td>3.70</td>
<td>4.09</td>
</tr>
<tr>
<td>Secondary Year 2</td>
<td>15.38</td>
<td>15.38</td>
<td>15.38</td>
</tr>
<tr>
<td></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Secondary Year 3</td>
<td>30.77</td>
<td>0.00</td>
<td>15.38</td>
</tr>
<tr>
<td></td>
<td>50.00</td>
<td>15.38</td>
<td>33.33</td>
</tr>
<tr>
<td>Total Secondary Level</td>
<td>46.15</td>
<td>15.38</td>
<td>30.77</td>
</tr>
<tr>
<td></td>
<td>30.77</td>
<td>50.00</td>
<td>44.44</td>
</tr>
<tr>
<td>Tertiary Degree</td>
<td>7.69</td>
<td>0.00</td>
<td>3.85</td>
</tr>
<tr>
<td>Certificate/ Diploma</td>
<td>7.69</td>
<td>7.69</td>
<td>21.43</td>
</tr>
<tr>
<td>Total Graduate Level</td>
<td>15.38</td>
<td>7.69</td>
<td>11.54</td>
</tr>
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<td></td>
<td>21.43</td>
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<td></td>
<td>7.69</td>
<td>14.81</td>
<td>18.52</td>
</tr>
<tr>
<td></td>
<td>15.38</td>
<td>7.69</td>
<td>13.21</td>
</tr>
</tbody>
</table>
4.2 Research procedure

The research project, including the interview schedule, was approved by the Swinburne Human Research Ethics Committee (SUHREC Project 0607/212). The research was also conducted with permission from the Upper Nile, South Sudan Relief and Rehabilitation Committee (SSRRC) and World Vision South Sudan (refer to Appendices I and J). Although World Vision was not directly involved with the research project, some support was provided by the organisation on the basis that the researcher was, at the time, under its employ. All interviews were conducted in Malakal, the township capital of the Upper Nile of South Sudan (see Appendix A for a locality map). Interviews were held over a 10 day period in January 2008.

At the time of data collection and interviews, World Vision had been working in Malakal South Sudan since the 2005, with the researcher supporting a range of programs in the area including livelihoods initiatives, food aid, education promotion for girls, support to restore local school and health facilities. Programs for mental health and psychosocial support (MHPSS) were poorly understood by World Vision South Sudan at the time, hence their interest and basic support for this study. However, based on MHPSS not being a strategic area for World Vision, funding for the research was not specifically allocated. Therefore, the study was completed by the researcher in periods of annual leave (connected to field programming visits to the World Vision projects) and with personal funding independent of the organisation. The study was completed in as short a time possible and with limited financial resources. This significantly influenced the research design, sampling methodology, translations and other relevant logistical matters.

Prior to interviews with participants, 3 days of preparations were undertaken. First, a World Vision employed Community Mobiliser was briefed about the research and participant selection criteria. When participants agreed to be involved in the study they were allocated a
time and day to attend the interview. World Vision provided some participants, particularly women, with transportation to and from the interviews, which were held at the offices of World Vision South Sudan in Malakal. All participants were offered light refreshments before, during or after the interviews (biscuits and water/soda).

The researcher paid the translator for the duration of the in-field data collection process. The translator spoke Arabic, Shilluk (local tribal language) and English. The translator received half-day training about the research project and matters of confidentiality were emphasised. The translator signed an agreement form confirming training received and confidentiality of all participants involved in the project (see Appendix C). As part of preparations, the translator and researcher studied the interview contents and analysed any words or concepts that did not translate well to local language, making minor adjustments as required. Following this, two South Sudanese World Vision staff volunteered to be interviewed as pilots. This provided the researcher and translator opportunity to refine the interview process and make any final adjustments to the interview schedule. Data from these pilot interviews were not included in the final data analyses.

At the beginning of each interview, participants were read a Verbal Consent Form, which outlined the purpose of the study, procedures for the interview, possible risks and benefits, confidentiality and reiteration of the voluntariness of their participation (refer to Appendix D). Recording of the interviews began when participants were asked if they had understood the information, whether they had any questions and if they were happy to proceed. The demographic and basic needs data, followed by the qualitative data were collected verbally through the translator, with all responses recorded via cassette recorder and an MP3 device. Recordings were switched off for the administration of the standard questionnaires – the Perceived Social Support Scale for Family and Friends, the Acculturative Stress Scale, the Harvard Trauma Questionnaire (HTQ) and the Hopkins
Symptom Checklist-25 (HSCL-25). All questionnaires were administered verbally and recorded by the researcher on paper. Participants were provided with pictorial cues to remind them of their response options. One was used for the perceived social support scales and acculturative stress scale (refer to Appendix E) and another used for the HTQ and HSCL-25 (refer to Appendix F).

Most of the participants spoke in their local Shilluk language (with Arabic derivatives). The translator summarised their responses using as much of their own words and information as possible. Because the translator was not formally trained in translation skills, he was unable to translate responses directly. Therefore many responses were translated in the second person, such as “he is saying” or “she says”. While this is a notable weakness of the qualitative information collected, it was not prohibitive to establishing common themes and ideas about individuals and their perceptions about mental health.

Some participants with English skills (n=7) initially attempted to respond to the questions in English. However, most English-speaking participants struggled and reverted back to translation, including a number who were requested to do so after appearing to have difficulty with English vocabulary. Some participants demonstrated interesting body language or affective presentation; these were noted by the researcher and reported as part of the qualitative analysis in Study 2.

Each interview, including qualitative and quantitative data collection, took between 55 minutes and 155 minutes (n=50, M=73.2 minutes, S.D.=16.71 minutes) with women recording slightly longer discussions than men (men, n=24, M=68.33 minutes, S.D.=11.00 minutes; women, n=26, M=77.69 minutes, S.D.=19.81 minutes). For some participants who provided only brief comments to the questions asked, prompting questions were used to encourage greater detail, depth or content. Some clarification questions were also used during interviews. Samples of prompting and clarification questions recorded in the
Interview transcripts are provided in Appendix G. For the participants’ whose interviews went longer, this was usually a result of their desire to ‘tell their story’ and provide considerable detail about their lives, past and present situations and future hopes. Participants were informed that they could offer as little or as much information as they felt comfortable in doing, thus the long average interview time was not inappropriate.

Following the individual interviews, the researcher undertook a key informant interview with the translator. The translator was also provided a final reminder about confidentiality and payment for services rendered was finalised.

4.3 Materials

Cross-cultural psychosocial interventions and research materials are recommended to undergo significant adaptation processes and documentation to ensure cultural centeredness prior to implementation (Bernal & Saez-Santiago, 2006; Bolton, 2001). Such approaches require translation procedures, instrument validity testing and other reliability analyses. Budget and time constraints during the current study severely limited options for such detailed pre-data collection activities. Therefore, the majority of materials selected for the quantitative data collection in the first study were selected, largely, due to their prior use with cross-cultural research participants, implementation of non-English translations of the measures and literature that suggested their retained validity and reliability attributes.

A semi-structured interview schedule was developed for the study with eight main components, some of which consisted of materials for the first study and others for the second study. Data collection for the two studies was amalgamated to ensure timeliness for the interviews and an adequate flow for the participants. In summary and representing the order in which the questions were asked of the participants, the research measures were as follows:
1. Demographic data (e.g., age, host or returnee status, marital status);

2. Basic Needs questions (Study 1);

3. Free Listing Ethnographic qualitative questions based on a study by Bolton, Neugebauer and Ndogoni (2002) that explored local perceptions of community issues and mental illness (Study 2);

4. Qualitative questions based on the Cultural Formulation of the DMS-IV-TR (APA, 2000) (Study 2);

5. Qualitative questions exploring participants’ perceptions of control over their current situation and their views about their future (Study 2);

6. Perceived Social Support Scales for Family and Friends (Prociando & Heller, 1983) (Study 1);

7. Catwe Acculturative Stress Scale (cited in Berry, Kim, Minde & Mok, 1987) (Study 1);

8. Harvard Trauma Questionnaire (Mollica, McDonald, Massagli & Silove, 2004) (Study 1); and

9. Hopkins Symptom Checklist-25 (Mollica et al.) (Study 1).

4.3.1 The interview schedule

A copy of the final interview schedule is provided in Appendix B. During pilot interviews with community volunteers it was agreed that some questions within the demographic and basic needs data would be removed from the interview schedule. For instance, due to significant disruption of schooling for the majority of participants, it was difficult for them to directly ascertain if they were educated as adults or children, as many experienced both and at various levels or time-periods. It was therefore determined more suitable to focus on level of educational attainment. One demographic/basic needs question was removed from the interview schedules, which related to how long it took people to walk for water. This was not considered relevant in the township environment as most people had
relatively local access to water either from town taps or the nearby river; and the focus on whether this was a clean source was deemed more pertinent to the measures of access to basic needs. Furthermore, while the overall content of the qualitative interview schedule did not change, a slight modification of order occurred after the first five participant interviews. Questions from the DSM-IV-TR Cultural Formulation (APA, 2000), namely tribal affiliation, social groups and local laws, were asked of the participants after the demographic information was sought as this produced a better flow for the discussions.

An additional question was added to the interview schedule approximately mid-way through the qualitative interviews. This was deemed necessary due to the common responses being received about causes of mental illness. Therefore, a question prompting more details about this topic was asked, such as “Many people in Sudan do not get what they need, so why do some people suffer emotional and mental health problems and others do not?” Responses to this question are examined in the Results section of the second study in an attempt to more fully explain local perceptions about the causes of mental illness.

4.3.2 Demographics data

Demographic information was collected verbally and based on simple measures of participant age, gender, marital status and whether or not individuals had children. These data, as well as identifying participants to be part of either the host or returnee groups, were utilised in various data analyses in the results.

In typical western studies, the concept of basic needs, such as employment or housing, is sometimes referred to as demographic data and, as such, some of this overview information was previously provided in the description of participants. However, for the purposes of the present study (specifically, Study 1), basic needs were defined as a distinct construct and measured separately to determine its possible influence on mental health and wellbeing.
4.3.3 Basic needs data and measure

In the present study the construct of basic needs was theoretically driven by four related principles, all of which have been outlined in detail in Chapter 1: Research Introduction. First, the notion of Maslow’s (1954) primary biological and physiological deficiency needs. Second, the Interagency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007) that grounds the basis of wellbeing in having access to basic services and security. Third, basic needs as a key aspect of the Economic, Social and Cultural Rights (UN, 1966), where quality of life is inherently linked to basic needs, life, liberty and security. The final theoretical driver for the construct of basic needs was Sachs’ (2005) definition of extreme poverty, whereby households and the individuals within them usually struggle to meet their food, health care, and water needs and are often unable to afford education and adequate shelter. Poverty and lacking in access to basic needs is commonplace in developing contexts, including South Sudan. While western research or prior cross-cultural psychopathology studies have often taken the notion of basic needs as a given, or as being unrelated to wellbeing (Summerfield, 2008), the current study’s sample group, research location and specific hypotheses justifies basic needs being treated as a discrete construct, and indeed requires the construct of basic needs to be established as a unique measure in order to ascertain its possible relationship to mental health.

Grounded in theories about poverty and basic needs, the following elements were used to build a basic needs measure: the number of meals consumed per day, common experiences of hunger, access to clean water, type of housing (or shelter), access to health care, highest level of education attained and engagement in steady employment. Based on the author’s experience of working in developing and poverty contexts, including South
Sudan, the categorical data from these basic needs variables were converted to ordinal data scores and summed to generate a Basic Needs Total Score. Scores worked on the rationale that lacking in basic needs was represented by low scores, while higher scores were representative of participants who had better access to and capacity to meet those needs. The following describes each basic needs variable, their allocated scores and the reasoning for those scores and ranges:

*Meals per day* - Scores for meals per day were not converted as this was a scaled score in the original data, ranging from 1 meal per day to 2 meals per day.

*Common experiences of hunger* - To determine common experiences of hunger, scores simply represented a low score for people who reported having commonly experienced hunger (=0) and a score of 1 if participants did not report common experiences of hunger. Thus, scores ranged from 0 to 1.

*Access to clean water* - Access to clean water determined that river water was the most unsafe water source, followed by untreated town water from taps. Clean water was considered the ideal water source deserving of the higher score. Therefore, water scores ranged from 0 to 2: River water = 0, town water = 1, and clean water = 2.

*Type of housing* - All participants in the research had access to housing, but the type of housing differed in its capacity to provide safety, security and shelter from the elements. Therefore, type of housing scores were indicative of some form of shelter being better than no shelter (hence no zero score), but that locally built structures (called Rukaba’s) did not offer as much safety or hygiene as a solid building, usually constructed with brick or concrete. Therefore, type of housing scores ranged from 1 to 2 with Rukaba’s = 1 and Solid Buildings = 2.

*Access to health care* - Access to health care scores worked on the assumption that in the South Sudan context, a local health clinic usually offers more regular and
individualised health care than the local hospital, which is generally reserved for medical emergencies. Naturally, having access to either a health clinic or the hospital was still considered preferable to having no access to health care at all. Scores for access to health care ranged from 0 to 2, based on the following: No health clinic = 0, town hospital = 1, local health clinic = 2.

_Highest level of education attained_ – This variable was converted using intervals of 0.5 per level as the breakdown was considerably greater than other basic needs items. This helped to ensure that the Basic Needs Total Score, based on ordinal data scores, was not inflated by the education variable. There were eight categories for highest level of education attained with scores ranging from 0 to 4, as follows: No Education = 0, Early Primary (Yr 1-4) = .5, Late Primary (Yr 5-8) = 1, Secondary Year 1 = 1.5, Secondary Year 2 = 2, Secondary Year 3 = 2.5, Certificate/Diploma = 3, Tertiary = 4.

_Steady employment_ - Steady employment was deemed more important to individuals’ capacity to meet their basic needs than the type of jobs they engaged in; thus employment was scored as either 0 for no steady employment or 1 for steady employment, with scores for steady employment ranging from 0 to 1.

Using this ordinal approach to scoring basic needs variables and summing them together, the Basic Needs Total Scores ranged from a minimum of 2 to a maximum of 14, with the lower rangeindicative of participants having fewer or less access to their basic needs. Figure 10 provides a depiction of the distribution of Basic Needs Total Scores. This graph suggests that the approach of summing the basic needs variables to a total score offers a practical way of observing the spread of people in the sample group and their levels of access to basic needs.
Figure 10. Distribution of Basic Needs Total Scores (N=53)

Although some data about basic needs has already been provided in Chapter 4.1, Table 3 provides a summary of the frequencies for each of the basic needs variables and the total scores for the sample group (returnees plus host). It shows that 77.4% of the participants reported commonly experiencing hunger. The majority of the sample group lived in traditional Sudanese housing and more than 50% of participants did not have access to a local health clinic. While the most common education level was completion of secondary education, the majority of participants (62.3%) did not have access to steady employment. Based on the composite score that comprised the Basic Needs Total Score, 50% of the participants attained a score above or below 6.8 out of a highest possible score of 14, but with the most frequent total score of 4, it suggests that the vast majority of people participating in this research lacked in their capacity to meet their basic survival needs.
These frequencies identified some missing data across the basic needs items, which were managed in subsequent analyses and results.

Table 3

*Frequencies of basic needs variables and total scores*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Missing Data</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>Median</th>
<th>Mode</th>
<th>Ordinal Scores</th>
<th>%</th>
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<td>0</td>
<td>0</td>
<td>62.3</td>
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<td>35.8</td>
</tr>
</tbody>
</table>

Ideally, the Basic Needs measure would be tested for test-retest reliability, inter-rater reliability, discriminant-convergent reliability and so forth. However, this measure was not intended to be a fully developed scale – rather, a measure that provided a total score to represent the concept of basic needs. Also, as an ordinal scale, the Basic Needs Total Score
and its variables was not tested for internal reliability because the individual items were not expected to be measuring similar or directly related constructs. For example, people in South Sudan may have regular access to food, but this may be unrelated to their access to clean water, health care or educational attainment. Nonetheless, some relationships were expected among the basic needs items. These were assessed using Spearman’s Rho correlation, which is commonly used for continuous ordinal scores and where assumptions or normal distribution have not been confirmed (Huizingh, 2007).

Spearman’s correlations measured the relationships of basic needs to all other key variables, and are outlined in Table 4. Table 4 shows a low to moderate, but significant relationship between educational attainment and employment ($r_s = .35$, $n=52$, $p<.01$), and a moderately significant relationship for people of higher education having better access to health care ($r_s = .30$, $n=48$, $p<.05$). However, as expected, some items that did not correlate, such as the non-significant relationships between individuals’ meals per day and whether or not they commonly experienced hunger, and between having access to clean water and type of housing. Based on the author’s experience of the South Sudan context, this is not surprising because the lack of basic needs that comprise poverty is not a linear relationship. For instance, having good quality shelter or a home in South Sudan may not correlate to having access to clean water because there is no systematic plumbing infrastructure supporting the townships. Also, people may still manage to find food for their standard 2-meals per day, but this does not preclude people from being hungry if they are not consuming nutritious or filling meals. Thus, while some basic needs variables revealed a direct relationship to other basic needs variables, this was not the case for all items that were summed to generate the Basic Needs Total Score; and while the approach to the Basic Needs Total Score and measure is unlikely to result in a scale with high internal consistency, the
theoretical basis of the variables all contributing to a depiction of a basic needs measure was considered adequate for the current research questions.

To further explore the relationships among the basic needs variables, the data were analysed according to population group, to ensure the scores were derived from a relatively analogous group. Chi-square tests for independence assessed the associations between the sample groups (host or returnee) and gender. Tables 5 and 6 show that for the majority of the basic needs variables, there was no significant relationship with gender. There were, however, two exceptions where significant differences between men and women existed in relation to access to clean water and highest levels of education achieved.
Table 4

*Spearman’s Rho correlations across basic needs variables and the Basic Needs Total Scores*

<table>
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<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
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<td>( N )</td>
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<td>.18</td>
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<td>.22</td>
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<td>Common experiences of hunger</td>
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<td>.49***</td>
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</tr>
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<td>-.16</td>
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</table>

*\( p<.05 \), **\( p<.01 \), ***\( p<.001 \)
Table 5

Summary of chi-square test for independence between basic needs variables and gender

<table>
<thead>
<tr>
<th>Basic needs variable</th>
<th>N</th>
<th>Pearson’s $\chi^2$</th>
<th>Df</th>
<th>Phi</th>
<th>Cramer’s V</th>
<th>Contingency Coefficient</th>
<th>Fisher’s Exact Test</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Monte Carlo Sig.</th>
<th>Lower bound (99%)</th>
<th>Upper bound (99%)</th>
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<td>1</td>
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</tbody>
</table>

$^+$ to account for violations in expected frequencies, due to the small sample size, Chi$^2$ tests of independence were conducted with exact and Monte Carlo (with a 99% confidence limit and 10,000 samples)

$^+$ Where the variable has only 2 categories, the Yates Continuity Correction value is provided

*Significant at $p<.05$

**Significant at $p<.01$
Table 6

Summary of chi-square test for independence between basic needs variables and group (host and returnee groups)

<table>
<thead>
<tr>
<th>Basic needs variable(^\text{a})</th>
<th>N</th>
<th>Pearson (\text{'}s \chi^2)</th>
<th>Df</th>
<th>Phi</th>
<th>Cramer's (V)</th>
<th>Contingency Coefficient</th>
<th>Fisher’s Exact Test</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Monte Carlo Sig.</th>
<th>Lower bound (99%)</th>
<th>Upper bound (99%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meals per day(^+)</td>
<td>49</td>
<td>.00</td>
<td>1</td>
<td>-.03</td>
<td>.03</td>
<td>.03</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Common experiences of hunger(^+)</td>
<td>49</td>
<td>1.82</td>
<td>1</td>
<td>-.24</td>
<td>.24</td>
<td>.24</td>
<td>-</td>
<td>.17</td>
<td>.13</td>
<td>.12</td>
<td>.14</td>
</tr>
<tr>
<td>Access to clean water</td>
<td>47</td>
<td>1.26</td>
<td>2</td>
<td>.16</td>
<td>.16</td>
<td>.16</td>
<td>1.32</td>
<td>.53</td>
<td>.55</td>
<td>.54</td>
<td>.57</td>
</tr>
<tr>
<td>Type of housing(^+)</td>
<td>51</td>
<td>.60</td>
<td>1</td>
<td>-.15</td>
<td>.15</td>
<td>.14</td>
<td>-</td>
<td>.43</td>
<td>.37</td>
<td>.36</td>
<td>.39</td>
</tr>
<tr>
<td>Access to health care</td>
<td>48</td>
<td>.40</td>
<td>2</td>
<td>.09</td>
<td>.09</td>
<td>.09</td>
<td>.51</td>
<td>.81</td>
<td>.90</td>
<td>.89</td>
<td>.91</td>
</tr>
<tr>
<td>Highest level of education attained</td>
<td>53</td>
<td>6.86</td>
<td>7</td>
<td>.36</td>
<td>.36</td>
<td>.34</td>
<td>6.71</td>
<td>.44</td>
<td>.48</td>
<td>.47</td>
<td>.49</td>
</tr>
<tr>
<td>Steady employment(^+)</td>
<td>52</td>
<td>.33</td>
<td>1</td>
<td>.12</td>
<td>.12</td>
<td>.11</td>
<td>-</td>
<td>.56</td>
<td>.55</td>
<td>.54</td>
<td>.57</td>
</tr>
</tbody>
</table>

\(^\text{a}\) to account for violations in expected frequencies, due to the small sample size, Chi\(^2\) tests of independence were conducted with exact and Montel Carlo (with a 99% confidence limit and 10,000 samples)

\(^+\) Where the variable has only 2 categories, the Yates Continuity Correction value is provided

*Significant at \(p<.05\)

**Significant at \(p<.01\)
Further gender analyses revealed that men tended to have greater access to town water (62.5%) than women (48.9%), but only women seemed to have access to clean water sources (12.8% compared with 0% of men). With regard to education by gender, men revealed significantly higher levels of education attainment than women, with 20.8% of men completing secondary school (to secondary year 3), while 17% of women obtained no education at all and a further 15.1% only completed primary school (to primary year 8). These gender differences for access to clean water and highest level of education attained are easily explained by the context of South Sudan and the roles of men and women in that social structure. Women would be more likely to have access to clean water sources because they are the primary water collectors in families in the South Sudanese culture. With regard to education, men’s education has, according to local custom and culture, always been more revered and considered more valued than women’s education. This is because the role of women is perceived to be focused on the family and home tasks as opposed to paid employment, which has traditionally been the role of men.

A review of the Basic Needs measure examined the influence of the high range or educational attainment scores, which may have impacted the weighting of the Basic Needs Total Scores. However, analyses determined that excluding education from the total score yielded not significant differences; and based on education being so inherently linked to the theoretical basis of poverty, it was maintained as an item of the Basic Needs Total Score measure.

In summary, the Basic Needs Total Score measure was deemed adequate and suitable for hypothesis testing. It was acknowledged that the measure would not be highly reliable by standard reliability tests – the constructs, though related, would not always be directly or logically linked. Nonetheless, the theoretical basis for their inclusion is well grounded and contextually relevant. Further, even though some inter-item correlations and gender
associations were found across the variables, these were explainable by the Southern Sudanese culture, the nation’s developing context and its peoples’ customs, suggesting that they would not hinder their use in the present study. Despite the possible weaknesses of the newly constructed measure, which is a summation of the basic needs variables, it was deemed appropriate for the analyses to utilise the Basic Needs Total Score to ascertain its links with mental health and wellbeing. However, to ensure greater stability and clarity of the results in the hypotheses testing process, the individual variables and the Basic Needs Total Scores were considered separately.

4.3.4 Perceived social support

The current research utilised the concept of social support as a way for people to receive physical and emotional comfort, and sometimes practical support, from their families and others in their communities, specifically friends (House, 1981). As a latent construct, the Perceived Social Support Scale developed by Procidano and Heller (1983) was used to measure the separate family and friendship elements of perceived and actual (or practical) social support in the current sample.

The Perceived Social Support questionnaire consists of two 20-item subscales; one each for social support from family and the other for social support from friends. A total of the two scales (social support from family plus social support from friends) were used to provide an overall Total Perceived Social Support measure. Items within the questionnaires were simple statements based on the ideals of both actual and perceived social support, such as “My family gives me a lot of encouragement”, “I get practical advice from my family”, “My friends give me the moral support I need” and “My friends are good at helping me solve problems”. In all, three total Perceived Social Support scales were used: the Perceived Social Support from Family subscale, Perceived Social Support from Friends subscale plus the Total
Perceived Social Support, which provided an overall picture of the sample groups’ perceived social support from both their family and their friends.

Although Procidano and Heller’s (1983) scale was not validated for use in a developing context or within Sudan, it was selected for translation and utilisation in the present study because it was a parsimonious scale with simple Yes/No/Don’t Know responses, which was deemed easier to verbally administer. Also, the scale enabled a measure of family and communal social supports and explored both practical and emotional support provided by others. This was considered vital for the South Sudan context where practical support can be intrinsically related to survival in addition to wellbeing, as explored in the Introduction chapters by way of social capital. Finally, the scale’s scoring methodology was straightforward in helping to ascertain high or low social support from each subscale (Thompson & Heller, 1990).

Justification for the use of the scale in the present study was consistent with its original development to determine the extent that respondents perceived they were receiving practical and emotional support from family and friends. In USA-sample groups, Procidano and Heller (1983) reported strong internal reliability of the two-part scales with a Cronbach’s Alpha of .88 for social support from friends and .90 for social support from family.

Scoring of Procidano and Heller’s (1983) Perceived Social Support Scale from Family and Friends was based on that original validation study. A response to each statement on the family or friends 20-item subscales indicated perceived social support. Thus, scores ranged from -20 representing no perceived social support to a maximum score of 20 for high social support. Each positive response of “yes” for social support scored +1; each negative response of “no” for social support scored -1. The “Don’t Know” category was not scored (Don’t Know = 0). In the Perceived Social Support subscale for family, five items, such as “Most other people are closer to their families than I am to mine” were reverse scored (item
numbers 3, 4, 16, 19 and 20). In the Perceived Social Support subscale for friends, five items were also reverse scored, such as “I wish my friends were much different (items 2, 6, 7, 15, 18 and 20).

The current study analysed the reliability of the Perceived Social Support subscales, expecting some challenges given the different context and translation of the original measure. After determining that there were no missing values in the data set and relevant items were reversed, reliability tests for the two questionnaires – Perceived Social Support from Family and Perceived Social Support from Friends – were tested to ascertain the internal consistency of the subscales. Reliability tests were conducted on each subscale separately.

The outcomes of the reliability analysis for the 20-item Perceived Social Support from Family subscale are outlined in Table 7. In the first iteration of the reliability analysis the Cronbach’s Alpha coefficient of .61 was below the recommended .7 level for scale reliability (Pallant, 2007). Two items revealed zero variance and were removed from the subsequent Cronbach’s Alpha calculations. The analysis also showed a possible increase of Cronbach’s Alpha if items 5 and 20 were removed. Therefore, a further reliability analysis was conducted, excluding the two zero variance items (items 14 & 15) plus the two items recommended in the model for an improved Cronbach’s Alpha (items 5 & 20). This second iteration yielded a slightly stronger Cronbach’s Alpha coefficient of .68, but still indicated some inconsistency. The model further recommended removal of more items, specifically items 12, 16 and 19. Thus, a third reliability analysis, excluding items 5, 12, 14, 15, 16, 19 and 20 was tested. This third iteration revealed an acceptable degree of internal consistency (Cronbach’s Alpha = .73), based on a revised 13-item Perceived social Support from Family Subscale.
Table 7

*Reliability analysis for Perceived Social Support from Family subscale*

<table>
<thead>
<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
<th>Cronbach's Alpha if Item Deleted (Iteration 1)</th>
<th>Cronbach's Alpha if Item Deleted (Iteration 2)</th>
<th>Cronbach's Alpha if Item Deleted (Iteration 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My family gives me a lot of support</td>
<td>.92</td>
<td>.38</td>
<td>.60</td>
<td>.69</td>
<td>.73</td>
</tr>
<tr>
<td>2. I get practical advice from my family</td>
<td>.74</td>
<td>.68</td>
<td>.60</td>
<td>.69</td>
<td>.73</td>
</tr>
<tr>
<td>3. Reversed Item: Most other people are closer to their families than I am to mine</td>
<td>.09</td>
<td>.99</td>
<td>.59</td>
<td>.69</td>
<td>.76</td>
</tr>
<tr>
<td>4. Reversed Item: When I share important personal thoughts with members of my family who are closest to me, it seems to make them uncomfortable</td>
<td>.58</td>
<td>.82</td>
<td>.57</td>
<td>.67</td>
<td>.73</td>
</tr>
<tr>
<td>5. My family enjoys hearing about what I think</td>
<td>.72</td>
<td>.69</td>
<td>.65</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Members of my family share many of my interests</td>
<td>.74</td>
<td>.68</td>
<td>.59</td>
<td>.68</td>
<td>.72</td>
</tr>
<tr>
<td>7. Certain members of my family talk to me when they have problems or need advice</td>
<td>.81</td>
<td>.59</td>
<td>.57</td>
<td>.66</td>
<td>.71</td>
</tr>
<tr>
<td>8. I rely on my family for emotional support</td>
<td>.32</td>
<td>.96</td>
<td>.56</td>
<td>.64</td>
<td>.70</td>
</tr>
<tr>
<td>9. There is a member of my family I could talk to if I were upset or discouraged, without regretting the conversation</td>
<td>.77</td>
<td>.64</td>
<td>.62</td>
<td>.70</td>
<td>.75</td>
</tr>
<tr>
<td>10. My family and I express our opinions openly</td>
<td>.77</td>
<td>.64</td>
<td>.55</td>
<td>.65</td>
<td>.69</td>
</tr>
<tr>
<td>11. My family is sensitive to my personal needs</td>
<td>.49</td>
<td>.87</td>
<td>.55</td>
<td>.64</td>
<td>.68</td>
</tr>
<tr>
<td>12. Members of my family come to me for emotional support</td>
<td>.62</td>
<td>.79</td>
<td>.62</td>
<td>.71</td>
<td>-</td>
</tr>
</tbody>
</table>
A reflection of the items deleted from the Perceived Social Support from Family subscale (refer to Table 7 above), suggests there may have been some translation difficulties with some of the questions, thereby resulting in their relatively low internal consistency. Three of the seven removed items from the questionnaire were reversed items, indicating that either the translation of reversed language or the responses to reversed language was a challenge in the research methodology. Item 5, “My family enjoys hearing what I think” and item 12, “Members of my family come to me for emotional support” share a common theme about individuals giving and receiving thoughts and ‘emotional support’. Such concepts may be foreign to the Sudanese culture, where support is usually viewed as being more practical and factual, rather than broad or speculative. Finally, the lack of variance in items 14 and 15...
were the result of all participants responding in the positive, saying “yes” to the questions “I have very close relationships with several members of my family” (Item 14) and “I give good practical advice to members of my family” (Item 15). While these items did not contribute to the reliability alpha of the subscale, it was decided to retain them for analyses; this outcome of 53 Sudanese individuals affirming that they have close relationships with their family members and offer practical advice to them is most likely a true reflection of this community. The Sudanese people place great importance to familial relationships, so a patterned yes response to these particular questions is likely an accurate depiction of their perceived engagement with family.

The initial reliability analysis for the 20-item Perceived Social Support from Friends subscale resulted in an extremely low Cronbach’s Alpha coefficient of .51. To achieve reliability of the subscale, various items had to be removed and the model retested. This process is detailed in Table 8, outlining the iterations for reliability and the adaptations made to the subscale to achieve a final and acceptable Cronbach’s Alpha of .70. To achieve this, items 2, 5, 6, 7, 15, 18 and 20 were removed from the Perceived Social Support from Friends subscale. Although Cronbach’s Alpha of .70 is still a relatively low reliability level, it is at the very least, approaching stability for use in hypothesis testing (Pallant, 2007). Item analyses indicated that removal of any additional items was not likely to greatly increase the reliability of the scale, thus use of the Perceived Social Support from Friends subscale proceeded with its 13 items. Based on this revision of the subscale measure, participants’ scores on the Perceived Social Support from Friends, with 13 items, ranged from -2 to 13 ($M=10.69, SD=2.93$).

In an overview of the items deleted from the Perceived Social Support from Friends subscale (refer to Table 8), there were some similar patterns to the unstable items deleted in the Perceived Social Support from Family subscale; namely, all reverse-scored items in the
Friends subscale were removed (items 2, 6, 7, 15 and 20). This supports the idea that either translation of reverse language questions was ineffective, or that participants were confused by how to respond to such questions. Item 5, “I rely on my friends for emotional support” was also similar to an item that proved unstable in the Perceived Social Support from Family subscale, indicating that the concept of ‘emotional support’ may have been strange to this particular sample group. However, it was interesting to note in this Perceived Social Support from Friends subscale, item 11 – “My friends come to me for emotional support” – did not reveal problems with internal inconsistency. It can only be speculated as to why this particular use of the term ‘emotional support’ was not as problematic, although the direction of providing emotional support may have contributed to the differences – in item 5 the question was about individuals seeking emotional support from others, which Sudanese people may see as a weakness, but in item 11 it was about giving emotional support, which the Sudanese people are likely to perceive as being an honourable thing to do.
Table 8

Reliability analysis for Perceived Social Support from Friends subscale

<table>
<thead>
<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
<th>(Iteration 1) Alpha = .51</th>
<th>(Iteration 2) Alpha = .60</th>
<th>(Iteration 3) Alpha = .67</th>
<th>(Iteration 4) Alpha = .69</th>
<th>(Iteration 5) Alpha = .70</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My friends give me the moral support I need</td>
<td>.81</td>
<td>.59</td>
<td>.47</td>
<td>.56</td>
<td>.63</td>
<td>.66</td>
<td>.66</td>
</tr>
<tr>
<td>2. Reversed Item: Most other people are closer to their friends than I am</td>
<td>-.11</td>
<td>.91</td>
<td>.49</td>
<td>.58</td>
<td>.65</td>
<td>.70</td>
<td>-</td>
</tr>
<tr>
<td>3. My friends enjoy hearing about what I think</td>
<td>.94</td>
<td>.30</td>
<td>.51</td>
<td>.60</td>
<td>.66</td>
<td>.68</td>
<td>.69</td>
</tr>
<tr>
<td>4. Certain friends come to me when they have problems or need advice</td>
<td>.96</td>
<td>.27</td>
<td>.51</td>
<td>.60</td>
<td>.67</td>
<td>.69</td>
<td>.71</td>
</tr>
<tr>
<td>5. I rely on my friends for emotional support</td>
<td>.32</td>
<td>.94</td>
<td>.51</td>
<td>.61</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Reversed Item: If I felt that one or more of my friends were upset with me, I'd just keep it to myself</td>
<td>.19</td>
<td>.98</td>
<td>.50</td>
<td>.62</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7. Reversed Item: I feel that I'm on the fringe in my circle of friends</td>
<td>.19</td>
<td>.98</td>
<td>.52</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8. There is a friend I could go to if I were just feeling down, without feeling funny about it later</td>
<td>.77</td>
<td>.64</td>
<td>.50</td>
<td>.57</td>
<td>.64</td>
<td>.67</td>
<td>.68</td>
</tr>
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<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>9. My friends and I are very open about what we think about things</td>
<td>0.89</td>
<td>0.47</td>
<td>0.51</td>
<td>0.61</td>
<td>0.67</td>
<td>0.70</td>
<td>0.72</td>
</tr>
<tr>
<td>10. My friends are sensitive to my personal needs</td>
<td>0.60</td>
<td>0.77</td>
<td>0.45</td>
<td>0.54</td>
<td>0.62</td>
<td>0.65</td>
<td>0.66</td>
</tr>
<tr>
<td>11. My friends come to me for emotional support</td>
<td>0.92</td>
<td>0.38</td>
<td>0.47</td>
<td>0.56</td>
<td>0.62</td>
<td>0.64</td>
<td>0.64</td>
</tr>
<tr>
<td>12. My friends are good at helping me solve problems</td>
<td>0.92</td>
<td>0.33</td>
<td>0.51</td>
<td>0.59</td>
<td>0.66</td>
<td>0.68</td>
<td>0.70</td>
</tr>
<tr>
<td>13. I have a deep sharing relationship with a number of friends</td>
<td>0.96</td>
<td>0.27</td>
<td>0.52</td>
<td>0.60</td>
<td>0.67</td>
<td>0.70</td>
<td>0.71</td>
</tr>
<tr>
<td>14. My friends get good ideas about how to do things or make things for me</td>
<td>0.94</td>
<td>0.30</td>
<td>0.52</td>
<td>0.61</td>
<td>0.68</td>
<td>0.70</td>
<td>0.71</td>
</tr>
<tr>
<td>15. Reversed Item: When I confide in friends, it makes me feel uncomfortable</td>
<td>0.58</td>
<td>0.82</td>
<td>0.52</td>
<td>0.62</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>16. My friends seek me out for companionship</td>
<td>0.92</td>
<td>0.38</td>
<td>0.48</td>
<td>0.57</td>
<td>0.65</td>
<td>0.68</td>
<td>0.69</td>
</tr>
<tr>
<td>17. I think that my friends feel that I am good at helping them solve problems</td>
<td>0.94</td>
<td>0.23</td>
<td>0.49</td>
<td>0.58</td>
<td>0.65</td>
<td>0.67</td>
<td>0.68</td>
</tr>
<tr>
<td>18. Reversed Item: Other people's friend relationships are more intimate than mine</td>
<td>0.36</td>
<td>0.83</td>
<td>0.48</td>
<td>0.61</td>
<td>0.69</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>19. I've recently gotten a good idea about how to do something from a friend</td>
<td>0.94</td>
<td>0.30</td>
<td>0.47</td>
<td>0.56</td>
<td>0.64</td>
<td>0.67</td>
<td>0.67</td>
</tr>
<tr>
<td>20. Reversed Item: I wish my friends were much different</td>
<td>-0.04</td>
<td>0.94</td>
<td>0.58</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

N=53
Although the final Cronbach’s Alpha of .73 for the Perceived Social Support from Family and the Cronbach’s Alpha of .70 for the Perceived Social Support From Friends are still well below Procidano and Heller’s (1983) reliability found in a USA sample (Family Cronbach’s Alpha=.90; Friends Cronbach’s Alpha=.88), this is not surprising given the considerable differences of cultures between the two research sample groups. It also reflects the tenuousness of taking western-validated measures for translation to a non-western context and sample group. The observation that reverse-scored items appeared to be especially challenging in the current research further supports the idea that direct translations do not directly yield the same results as those found in the homelands and cultures of where the measures were developed. Nonetheless, with adjustments, the subscales were deemed adequate for internal consistency for use in testing the research hypotheses. However, to further ensure reliability of the adapted subscales, items from the Revised Perceived Social Support from Family subscale (15-items) and the Revised Perceived Social Support Friends subscale (13-items) were combined to establish a Perceived Social Support Total scale (28-items) and score. This Perceived Social Support Total Scale was deemed internally consistent and reliable for further analysis (Cronbach’s Alpha=.77).

Following this, assumptions of normality were tested, beginning with descriptive statistics about the scale. Table 9 provides the mean, standard deviations and range scores for each of the three total Perceived Social Support Scales. Participants scores on the Total Perceived Social Support scale ranged from -4 to 28 with an average score of 22.08 (SD=5.97). Skewness of the scores was analysed using the Skewness-Z statistic, where anything above or below 3.29 is indicative of significant skewness (Tabachnic & Fidell, 2007). This is also shown in Table 9, which revealed that the two subscales plus the total Perceived Social Support Scale were significantly negatively skewed. Furthermore, in an analysis of outliers, two participants showed extremely low scores in the Perceived Social
Support Family and Perceived Social Support Friends subscales, which influenced the normal distribution of the Perceived Social Support Total Scores. These anomalies and violations of assumptions were noted and subsequently managed in the hypothesis testing and results.

Table 9

Descriptive statistics for Perceived Social Support Family and Friends Subscales and the Perceived Social Support Total scores

<table>
<thead>
<tr>
<th></th>
<th>Min.</th>
<th>Max.</th>
<th>M</th>
<th>SD</th>
<th>Skewness</th>
<th>Z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revised PSS Family Subscale (15-items)</td>
<td>-4.00</td>
<td>15.00</td>
<td>10.53</td>
<td>4.58</td>
<td>-1.46</td>
<td>0.33</td>
</tr>
<tr>
<td>Revised PSS Friends Subscale (13-items)</td>
<td>0.00</td>
<td>13.00</td>
<td>11.55</td>
<td>2.65</td>
<td>-2.59</td>
<td>0.33</td>
</tr>
<tr>
<td>Revised PSS Total Score (28-items)</td>
<td>-4.00</td>
<td>28.00</td>
<td>22.08</td>
<td>5.97</td>
<td>-2.06</td>
<td>0.33</td>
</tr>
</tbody>
</table>

N=53

4.3.5 Acculturative stress

As detailed in the Introduction (Chapter 2.4), Acculturative Stress refers to the psychological and somatic stress reactions people can experience during the processes of acculturating to a new or host society (Berry, 2006). In the present study, Acculturative Stress was measured using the Acculturative Stress Scale of Scale of Cawte, Bianchi and
Kiloh (1968), which was updated by Berry, Kim, Minde and Mok (1987) and Neto (1994). The 20-item scale consists of two subscales each with 10 somatic symptoms, such as “Do your muscles and joints constantly feel still” and 10 psychological symptoms such as “Does worrying continually get you down”. Responses are based on dichotomous yes/no scale. Yes responses were scored as +1, thus a minimum score was 0 with a maximum score of 10 for each subscale or 20 for an overall total acculturative stress score. High scores indicate high acculturative stress. There are no reversed score items.

The Acculturative Stress Scale of Catwe, Bianchi and Kiloh (1968) and its implementation by other researchers (such as Berry, Kim, Monde & Mok, 1987 and Neto, 1994) focused on acculturative stress amongst immigrant or refugee populations largely originating from developing countries and living in developed nations. To the author’s knowledge, this scale had not been employed in a developing context amongst returnee populations, the focus of the present research. However, the scale is parsimonious, which is an important prerequisite for cross-cultural studies. Furthermore it was expected to demonstrate differences of stress experiences between the host and returnee groups sampled, testing the hypothesis that returnees may be experiencing acculturative stress, even to their homeland, which may also be influencing their mental health and wellbeing.

The Acculturative Stress Scale of Catwe, Bianchi and Kiloh (1968) has broadly demonstrated acceptable internal reliability showing a Cronbach’s Alpha ranging from .69 (Neto, 2002a) in a study about Portuguese adolescent’s from migrant families, to .81 in Neto’s (1994) study of acculturative adaptation of Portuguese immigrants to Germany. Berry, Kim, Monde and Mok (1987) used the Acculturative Stress Scale in a study of acculturative stress amongst immigrants, refugees, Native peoples, and other ethnic groups living in Canada. The scale showed internal reliability Cronbach’s Alpha ranging from .7 to .8, depending on the population groups within the study. Berry et al. also validated the
Acculturative Stress Scale against other measures of stress and acculturation, reporting the measure to show strong face validity and practical utility for non-English speakers.

In the current study, reliability analyses were computed for each of the three Acculturative Stress Scale components. First, the 10-item Acculturative Stress Somatic Symptoms subscale, which was internally consistent with a Cronbach’s Alpha of .77. Second, the 10-item Acculturative Stress Psychological Symptoms Subscale was also internally reliable with a Cronbach’s Alpha of .75. Third, the Total Acculturative Stress Scale, comprising the 20-items of somatic and psychological symptoms revealed good internal reliability with Cronbach’s Alpha = .84, which is in line with previous reliability studies (Berry, Kim, Monde & Mok, 1987; Neto, 1994, 2002b). Table 10 provides the means, standard deviations and Cronbach’s Alpha if items deleted. It shows that all items of the Acculturative Stress Scale were contributing equally to the internal reliability of the scale. It also demonstrates some degree of face validity for the scale, with items 1 to 10 focused on somatic complaints with each question relating to a physiological symptom of stress, while items 11 to 20 all focus on psychological experiences of stress. As all questions in the scale are relatively straightforward and with this solid internal reliability, it suggests that the questions were easily translated and participants responded in appropriate ways.
Table 10

*Reliability analysis for Acculturative Stress Scale*

<table>
<thead>
<tr>
<th>Item</th>
<th>Cronbach's Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have pains in the heart or chest</td>
<td>M = .49, SD = .50, Alpha = .84</td>
</tr>
<tr>
<td>2. Do you usually belch a lot after eating</td>
<td>M = .34, SD = .48, Alpha = .83</td>
</tr>
<tr>
<td>3. Do you constantly suffer from bad constipation</td>
<td>M = .53, SD = .50, Alpha = .84</td>
</tr>
<tr>
<td>4. Do your muscles and joints constantly feel stiff</td>
<td>M = .60, SD = .49, Alpha = .84</td>
</tr>
<tr>
<td>5. Is your skin very sensitive or tender</td>
<td>M = .40, SD = .49, Alpha = .85</td>
</tr>
<tr>
<td>6. Do you suffer badly from frequent severe headaches</td>
<td>M = .53, SD = .50, Alpha = .83</td>
</tr>
<tr>
<td>7. Do you often have spells of severe dizziness</td>
<td>M = .43, SD = .50, Alpha = .83</td>
</tr>
<tr>
<td>8. Do you usually get up tired and exhausted in the morning</td>
<td>M = .58, SD = .50, Alpha = .83</td>
</tr>
<tr>
<td>9. Do you wear yourself out worrying about your health</td>
<td>M = .51, SD = .50, Alpha = .83</td>
</tr>
<tr>
<td>10. Do you usually have great difficulty in falling asleep or staying awake</td>
<td>M = .49, SD = .50, Alpha = .83</td>
</tr>
<tr>
<td>11. Do strange people or places make you afraid</td>
<td>M = .38, SD = .49, Alpha = .84</td>
</tr>
<tr>
<td>12. Do you wish you always had someone at your side to advise you</td>
<td>M = .79, SD = .41, Alpha = .84</td>
</tr>
<tr>
<td>13. Do you usually feel unhappy and depressed</td>
<td>M = .74, SD = .45, Alpha = .83</td>
</tr>
<tr>
<td>14. Do you often wish you were dead and away from it all</td>
<td>M = .28, SD = .45, Alpha = .83</td>
</tr>
<tr>
<td>15. Does worrying continually get you down</td>
<td>M = .64, SD = .48, Alpha = .83</td>
</tr>
<tr>
<td>16. Are you extremely shy or sensitive</td>
<td>M = .28, SD = .45, Alpha = .84</td>
</tr>
<tr>
<td>17. Does it make you angry to have anyone tell you what to do</td>
<td>M = .08, SD = .27, Alpha = .84</td>
</tr>
<tr>
<td>18. Do people often annoy or irritate you</td>
<td>M = .66, SD = .48, Alpha = .84</td>
</tr>
<tr>
<td>19. Do you often shake or tremble</td>
<td>M = .40, SD = .49, Alpha = .83</td>
</tr>
<tr>
<td>20. Do you often break out in a cold sweat</td>
<td>M = .42, SD = .50, Alpha = .83</td>
</tr>
</tbody>
</table>

N=53

Assumptions of normality for the Acculturative Stress Scale were tested, beginning with descriptive statistics about the scale. Table 11 outlines the mean, standard deviations
and range scores for the two Acculturative Stress Scales subscales (somatic and psychological) as well as for the total scores. Participants’ scores on the Total Acculturative Stress scale ranged from 0 to 19 with a mean score of 9.56 ($SD=4.75$). Skewness of the scores was analysed using the Skewness-Z statistic, which is also shown in Table 11. In this instance, there was no significant skewness in the Acculturative Stress Scale data. There were no missing values or outliers. Thus, this scale was deemed effective for analysis of the research hypotheses.

Table 11

*Descriptive statistics for Acculturative Stress Somatic and Psychological Symptoms subscales and the total score for the Acculturative Stress Scale*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Min.</th>
<th>Max.</th>
<th>M</th>
<th>SD</th>
<th>Skewness Statistic</th>
<th>Skewness Standard Error</th>
<th>Skewness-Z statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acculturative Stress Somatic Symptoms Subscale</td>
<td>0</td>
<td>10</td>
<td>4.90</td>
<td>2.84</td>
<td>-.07</td>
<td>.32</td>
<td>-.22</td>
</tr>
<tr>
<td>Acculturative Stress Psychological Symptoms Subscale</td>
<td>0</td>
<td>10</td>
<td>4.66</td>
<td>2.52</td>
<td>.04</td>
<td>.32</td>
<td>.13</td>
</tr>
<tr>
<td>Total Acculturative Stress</td>
<td>0</td>
<td>19</td>
<td>9.56</td>
<td>4.75</td>
<td>.05</td>
<td>.32</td>
<td>.16</td>
</tr>
</tbody>
</table>

$N=53$
4.3.6 Harvard Trauma Questionnaire (HTQ)

The original Harvard Trauma Questionnaire (HTQ) was specifically designed for the multiple trauma experiences of refugees who had migrated following conflict and formed part of clinical treatment and research programs (Mollica, McDonald, Massagli & Silove, 2004). The original HTQ that was used to specifically indicate symptoms of Posttraumatic Stress Disorder (PTSD) has been modified for many country, language and context specific requirements, but its basic construct has remained consistent. It has been established as a tool for use amongst refugees in developing countries as well as returnees to homelands in developing contexts.

The full HTQ clinical screening comprises five parts, including; (1) listing trauma events that have been experienced, witnessed or heard about; (2) providing a personal and subjective description of a person’s worst event; (3) a screening for brain/head injuries that may contribute to neuropsychological deficits (e.g., from beatings, suffocations, drowning, starvation, head injuries); (4) a 40-item scale of posttraumatic symptoms with three subdomains of Posttraumatic Stress Disorder (PTSD) – re-experiencing traumatic events, avoidance and numbing, and psychological arousal; and (5) a scoring algorithm that incorporates all five components and is adapted specifically for different cultures and/or conflict experiences.

The present research was not targeting clinical outcomes and sought only to measure mental health and wellbeing on the basis of more or less experiences of symptoms of PTSD, depression and anxiety. Therefore, the present study did not utilise the full HTQ or aim to adapt it specifically to the context. Rather, it solely utilised the fourth component of the HTQ comprising the 40-item scale of posttraumatic symptoms; an approach Mollica, McDonald, Massagli and Silove (2004) suggested as appropriate for research and replicated in other PTSD research by Renner, Salem and Ottomeyer (2006), which revealed a strong internal
reliability of the HTQ Part IV scale amongst West African asylum seekers in Austria ($\alpha=.95$). Similar validity coefficients were shown in a direct translation of the scale by Ward et al. (2004) amongst South African adolescents exposed to violence ($\alpha=.92$) as well as strong test-retest reliability (Cohen’s kappa $k = 0.64$ (95% CI = 0.51-0.74)).

The first 16 items of the HTQ hone in on PTSD symptoms based upon DSM-III-R/DSM-IV symptoms. Mollica, McDonald, Massagli and Silove (2004) suggested these could be used without cultural adaptation. These 16 items are broken down to three of the PTSD cluster symptoms including four items about re-experiencing events, such as “Feeling as though the event is happening again”; seven items about avoidance, such as “Feeling detached or withdrawn from people” and “less interest in daily activities”; and five psychological arousal symptoms, such as “feeling on guard” or “feeling jumpy, easily startled”. The remaining 24 items of Part IV of the HTQ were referred to as being ‘refugee-specific’ and intended to be contextually adapted (Mollica et al.). They focus on some of the most likely and most common experiences of displaced communities in relation to functioning and social disability, such as “Feeling unable to make daily plans”, “Hopelessness” and “Feeling that people do not understand what happened to you”. Broadly, the refugee-specific items relate to skills and talents; physical impairments; intellectual functioning; emotional functioning; social relationships and spiritual/existential concerns. Since these matters relate similarly for all conflict affected populations, as they do for refugee or displaced populations, it was deemed appropriate to use these measures amongst both the host and returnee groups in the present study.

Following a pilot interview of the HTQ with community volunteers, no significant changes were made to the items of the HTQ Part IV questionnaire, which is detailed in full in Appendix B. Participants’ responded on a likert scale, which for the purposes of the present study was scored as follows: “0=not at all”, “1=a little”, “2=quite a bit” to
“3=extremely”. Scores therefore ranged from a minimum of 0 representing no trauma symptoms to 120 indicating extreme trauma symptoms. A clinical cut-off score was not calculated or used in the present study.

Internal reliability for two subscales and the total Harvard Trauma Questionnaire (HTQ) were analysed. A 22-item subscale, broadly classified as ‘Other Impairments’, related to symptoms commonly experienced by refugees and conflict-affected populations (Mollica, McDonald, Massagli & Silove, 2004) and distinct from the diagnostic symptoms of Posttraumatic Stress Disorder (PTSD), was analysed. It generated a high Cronbach’s Alpha of .93. The second subscale of the HTQ consisted solely of the 18 items directly measuring typical avoidance, arousal, dissociative and re-experiencing symptoms of PTSD. This subscale also showed strong internal consistency with a Cronbach’s Alpha of .88.

The sum of the two subscales, Other Impairments and PTSD, combined to generate an overall HTQ score with a Cronbach’s Alpha of .95, which is consistent with previous research (Renner, Salem & Ottomeyer, 2006; Ward et al., 2004) that utilised this scale in other African sample groups. The Cronbach’s Alpha of .95 is extremely high and might suggest that some of the items are measuring similar constructs. However, in light of the HTQ being widely utilised in a wide variety of translations, countries and contexts, including contexts akin to South Sudan, and that the current reliability results are congruent with previous studies in Africa, the measure was deemed appropriate for use to test the research hypotheses.

For the two subscales and total HTQ scores, assumptions of normality were tested. Table 12 provides the mean, standard deviations and range scores for the three HTQ scales. Participant’s scores on the Total HTQ measure ranged from 0 to 99 (out of a possible 0-120 score range), with a mean score of 32.98 (SD=23.80). Skewness of the scores was tested
using the Skewness-Z statistic, which indicated that the scores were not significantly skewed across the sample group.

Table 12

*Descriptive statistics for Harvard Trauma Questionnaire (HTQ) for Posttraumatic Stress Disorder (PTSD) Symptoms, Other Impairment Symptoms and the Total Scores for the HTQ.*

<table>
<thead>
<tr>
<th></th>
<th>Min.</th>
<th>Max.</th>
<th>M</th>
<th>SD</th>
<th>Skewness-Z statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTQ PTSD Symptoms</td>
<td>0</td>
<td>42</td>
<td>13.58</td>
<td>10.17</td>
<td>2.82</td>
</tr>
<tr>
<td>HTQ Other Impairment Symptoms</td>
<td>0</td>
<td>57</td>
<td>19.40</td>
<td>14.55</td>
<td>2.09</td>
</tr>
<tr>
<td>HTQ Grant Total Symptoms</td>
<td>0</td>
<td>99</td>
<td>32.98</td>
<td>23.80</td>
<td>2.14</td>
</tr>
</tbody>
</table>

*N=53*

4.3.7 *Hopkins Symptom Checklist-25 (HSCL-25)*

Historically, the HSCL was developed and widely-used as a clinical screening and measurement instrument in the 1950s for the symptoms of anxiety and depression. It has undergone numerous modifications since that time with use amongst refugee populations first implemented in the 1980s. For a more detailed history of the development of the HSCL and its psychometric properties in various clinical and research populations, refer to Mollica, McDonald, Massagli and Silove, (2004). The 25-item HSCL was first established in the early 1980s (Hesbacher, Rickels, Morris, Newman, & Rosenfeld, 1980; Winokur, Winokur, Rickels, & Cox, 1984) taking 10 items from the original HSCL 64-item questionnaire anxiety cluster and 13 items from the depression cluster. Two additional somatic symptoms were included as part of the depression cluster. Thus the HSCL-25 is a 25-item questionnaire, with 10 items related to anxiety, such as “Feeling tense or keyed up” or “Suddenly scared for no
reason” and 15 items related to depression (including two somatic symptoms) such as “Feeling low in energy, slowed down”, “Poor appetite” and “Difficulty falling asleep or staying asleep”.

Though the current study aimed to broaden the understandings about mental health and wellbeing in the southern Sudanese context, by inclusion of considerable qualitative data, measures for other commonly experienced mental illnesses remained necessary to measure. It is widely established that populations exposed to war and forced migration are not only inclined towards PTSD psychopathology, but also depression and anxiety (Merali, 2008). Therefore, the HSCL-25 was employed in the present study based on its wide use cross-culturally, within Africa and as a recommended accompaniment to the Harvard Trauma Questionnaire (Mollica et al., 1996).

The HSCL-25 is now one of the most widely utilised instruments to measure depression and anxiety in Africa. It has been validated in Tanzania amongst HIV+ women with a Cronbach’s Alpha of .90 (Kaaya et al., 2002) and locally adapted and validated in Rwanda and Uganda (Bolton, Neugebauer & Ndogoni, 2002; Bolton, Wilk & Ndogoni, 2004).

Following the pilot of the interview schedule for the present study, including the HSCL-25 (refer to Appendix B), only one item had to be changed to account for language differences; from “Feeling blue” to “Feeling loose”, which the research translator indicated was a more valid term for the intended meaning of that item. All items in the study were scored similarly to the original HTQ with a minimum and maximum score range of 0, representing no symptoms to 75 indicating high number of symptoms. This was based on responses graded as 0=Not at all, 1=A little, 2=Quite a bit and 3=Extremely. Also similar to the HTQ utilisation in the current study, the measure was not implemented for diagnostic screening. Rather it was used to demonstrate low or high anxiety and/or depression
symptoms within the sample group, thus diagnostic cut-off scores for anxiety or depression were not calculated for the present study.

Three measures related to the Hopkins Symptom Checklist-25 (HSCL-25) were tested for reliability. First, the 10-item subscale known as the HSCL-25 Anxiety Subscale was analysed with items generating a Cronbach’s Alpha of .89. Second, the remaining 15 items comprising the HSCL-25 Depression Subscale was analysed for reliability, which indicated strong internal consistency with a Cronbach’s Alpha of .91. The two subscales were then combined for a Total HSCL-25 score, with the combined items also showing excellent internal reliability with a Cronbach’s Alpha of .95. Similar to the reliability analyses of the Harvard Trauma Questionnaire (HTQ), this is an extremely high reliability result. However, it is consistent with other utilisations of the scale in previous African sample groups (Kaaya et al., 2002) and was considered valid for the present study since it is one of the most commonly used depression and anxiety screening instruments in Africa (Bolton, Neugebauer & Ndogoni, 2002; Bolton, Wilk & Ndogoni, 2004; Mollica, Wyshak, de Marneffe, Khuon & Lavelle, 1987).

Normality assumptions were then tested, using descriptive statistics about the subscales and the Total HSCL-25 scale. Table 13 provides the mean, standard deviations and range scores for the three HSCL measures. Participants scores on the Total HSCL-25 measure ranged from 0 to 65 (within a possible range of 0-75) with a mean score of 18.28 (SD=15.90). Skewness of the scores was analysed using the Skewness-Z statistic, which is also shown in Table 13. In this instance, the HSCL Depression subscale was significantly positively skewed. This contributed to some skewness in the HSCL Total Score, but the final Skewness-z statistic (3.21) did not meet significance. The data were screened for outliers and while there were some high scores in the HSCL Depression Subscale, there was no abnormal pattern of responses that warranted exclusion of these cases from the data set. Therefore, the
data relating to the HSCL-25 scales were unchanged and utilisation of the measure for the research hypothesis testing proceeded.

Table 13

Descriptive statistics for Hopkins Symptom Checklist-25: Depression and Anxiety subscales and Total Scores

<table>
<thead>
<tr>
<th></th>
<th>Min.</th>
<th>Max.</th>
<th>M</th>
<th>SD</th>
<th>Skewness Statistic</th>
<th>Skewness Standard Error</th>
<th>Skewness -Z statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSCL Total Anxiety</td>
<td>0</td>
<td>24</td>
<td>6.57</td>
<td>6.51</td>
<td>.84</td>
<td>.33</td>
<td>2.56</td>
</tr>
<tr>
<td>HSCL Total Depression</td>
<td>0</td>
<td>41</td>
<td>11.72</td>
<td>9.90</td>
<td>1.18</td>
<td>.33</td>
<td>3.61</td>
</tr>
<tr>
<td>HSCL Total Symptoms</td>
<td>0</td>
<td>65</td>
<td>18.28</td>
<td>15.90</td>
<td>1.05</td>
<td>.33</td>
<td>3.21</td>
</tr>
</tbody>
</table>

N=53

4.3.8 Measuring mental health

The current study aimed to measure mental health from a continuum of symptoms representative of some of the more common mental illnesses literature has considered to be the psychological consequences of war, poverty and migration. These include depression, anxiety and Posttraumatic Stress Disorder (PTSD) and thus warranted the inclusion of Part IV of the Harvard Trauma Questionnaire (HTQ; Mollica, McDonald, Massagli & Silove, 2004) and the Hopkins Symptom Checklist-25 (HSCL-25; Mollica et al.). The previous chapters have provided details of these two measures and their reliabilities in the current
sample group. However, to combine the two measures as being representative of mental health, it was important to ascertain how they relate to each other. Given the total number of items of the two measures is 40 (HTQ) plus 25 (HSCL), a factor analysis to try and reduce the data into a smaller set of components was not feasible. Therefore, correlation analysis considered the relationship of the two total scores and expected that they might be significantly and strongly related as they both measure forms of mental illness.

Using the HSCL Total Scores and the HTQ Total Score, a preliminary analysis using the simple scatterplot was generated. It indicated the likelihood of a positive correlation between the HTQ and HSCL, showing that as individuals reported more symptoms of trauma on the HTQ, they appeared to also experience greater symptoms of depression and anxiety on the HSCL. The Pearson’s correlation analysis confirmed that there was a strong, positive and significant relationship between the total HTQ scores and the total HSCL scores ($r=.91$, $n=53$, $p<.001$). This outcome verifies the utilisation of the two HTQ and HSCL scales as measures of mental health and general mental wellbeing.

4.3.9 Qualitative methodology

A qualitative component of the research was considered essential to enable the research to explore the likely links between mental health and wellbeing and poverty, or lack of basic needs (WHO, 2001) and local perceptions of mental illness. Although qualitative data about mental illness in developing contexts is expanding, very few published accounts have been undertaken about mental illness in South Sudan specifically. This further justified the importance of building the understanding about mental health issues in this region of Africa. The qualitative questions developed and adapted for the semi-structured interview were based on well-recognised qualitative approaches undertaken in previous research. Further information is provided in Chapter 6.2, which provides a full account of the method and results for the second study.
4.4 Summary of methodology

The current study consisted of 53 participants from the Malakal township of South Sudan. The total sample comprised two groups; a host group (n=26) and returnee group (n=27) with relatively equal numbers of men and women in each group. Based on participants’ reports of their access to basic needs, or lack thereof, the majority of the sample group can be viewed as living in poverty conditions.

The research utilised a semi-structured interview format (refer to Appendix B), which was verbally administered with the support of a local translator. The interview schedule included qualitative questions, demographic questions and a series of questions related to participants’ access to basic needs. Measures about social support, acculturative stress, trauma, depression and anxiety were also applied. These quantitative measures were subsequently tested for reliability and their suitability for use in testing the research hypotheses.

A summed score representing access to or lack of basic needs was developed, consisting of the following variables: meals per day, common experiences of hunger, access to clean water, type of housing, access to health care, level of education attained and steady employment. As an additive scale, the Basic Needs Total Score was not tested for reliability, but the variables showed some inter-item relationships and, for the most part, appeared independent of gender or sample group biases.

The Perceived Social Support scales revealed some challenges in measuring this latent social support construct, with what appeared to be the influences of cultural differences to some of the concepts of social support in the measures’ variables. However, by removing many of the reverse-scored items and those that appeared to poorly translate to local language or concepts, a level of internal consistency was achieved for a 28-item scale, albeit lower than prior uses of the Perceived Social Support scale reported in western samples.
The Acculturative Stress measure showed strong reliability along with the Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptom Checklist-25 (HSCL-25). These instruments, which have been previously used and validated in non-English speaking sample groups and amongst populations with poor and war-torn background such as conditions common to South Sudan, appeared to translate well in the present study and indicated strong appropriateness for use. This conclusion was further supported by observing a strong, positive and significant correlation of HTQ and HSCL total scores, which will be applied as a broad and continuous measure of mental health and wellbeing in the following analyses and results.
CHAPTER 5: FIRST STUDY RESULTS - ANALYSIS OF INFLUENCES ON MENTAL HEALTH IN SOUTH SUDAN

The purpose of this chapter is to outline the results of the first study quantitative study, which examined the hypotheses detailed in Chapter 3.1. The first hypothesis of the current study focused on the total sample group and how the aspects of access to basic needs, social support and acculturative stress might influence their mental health, and whether or not social support mediated the relationship between participants’ access to basic needs and their subsequent mental health. The second hypothesis investigated whether there were differences in mental health according to which group the participants belonged – the host group, who never left South Sudan throughout the civil war and the group of recent returnees who had migrated back to their homeland, on average, within the past two years (time returned to South Sudan: $M=22.09$ months, $SD=19.25$ months). It was predicted, based on a moderation model that the influences of basic needs, social support and acculturative stress on mental health would differ across the two groups.

The third and fourth hypotheses were exploratory and were derived from the qualitative data. The qualitative data considered whether the total sample groups’ views about poverty were perceived as a greater need than mental health concerns or their trauma from the periods of war, and whether people would see their basic needs as inherently linked to their mental health and wellbeing. The data further sought to deepen understanding about how people in South Sudan conceptualised mental health and mental illness and what their local beliefs about such matters were. To address the fourth hypothesis, the qualitative data assessed how well the sample group perceived their feelings of control in their lives, their views of the future and whether or not this differed for the host and returnee groups.
Owing to the scarcity of mental health research in South Sudan and the small sample size of the present study, a preliminary exploratory analysis was conducted on the quantitative data, which considered a range of potential factors not included in the research hypotheses, but which might also be contributing to the respondent’s mental health and wellbeing (e.g., age and gender).

5.1 Preliminary quantitative exploratory analysis

The uniqueness of the study’s data set, the small sample size, the paucity of mental health literature from low and middle income countries, including Africa, and the dearth of mental health research that has purposely engaged Southern Sudanese participants living in their homeland, all warranted an exploratory examination of the data to try and identify any additional factors that may be related to mental health and wellbeing in South Sudan. This involved an exploration of gender differences and the possible influences of age, education, marital status and employment status on dependent variables like basic needs (abbreviated to BN), perceived social support (abbreviated to PSS), acculturative stress (abbreviated to AS) and the mental health indicators; namely the Harvard Trauma Questionnaire (HTQ) and Hopkins Symptom Checklist-25 (HSCL-25). Differences between the host and returnee groups are not reported in this chapter because they were analysed as part of the testing for the second research hypothesis (see Chapter 5.3 Hypothesis 2 results).

5.1.1 The influence of gender on basic needs, social support, acculturative stress and mental health

In the data screening process for the basic needs items and total scores (Chapter 4.3.3), it was identified that men and women in the sample group differed significantly in two areas of access to basic needs: women reported significantly higher access to clean water than men, while men reported significantly higher levels of educational attainment compared with women. Following the adaptation of the basic needs items to continuous measures, an
independent samples t-test further verified that men had obtained significantly higher levels of education than women \((t(51)=3.08, p<.01)\). Table 14 summarises the gender differences in educational attainment.

To further investigate gender differences in the sample group, a series of one-way between groups analyses of variances (ANOVA)s was performed. Gender constituted the independent variable but due to the small sample size, only the total scores of five dependent variables were assessed, as follows: Total Basic Needs Score, Total Perceived Social Support, Total HTQ scores and Total HSCL-25 scores. Table 15 presents the average scores by gender for each of the dependent variables, along with analysis of normal distribution/skewness patterns.

Table 14

**Frequencies of Completed Education Levels by Gender**

<table>
<thead>
<tr>
<th>Completed level of education</th>
<th>Males ((n=27)) %</th>
<th>Females ((n=26)) %</th>
<th>Total ((n=53)) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Education***</td>
<td>7.41</td>
<td>34.62</td>
<td>20.75</td>
</tr>
<tr>
<td>Early Primary (Yr 1-4)</td>
<td>3.70</td>
<td>11.54</td>
<td>7.55</td>
</tr>
<tr>
<td>Late Primary (Yr 5-8)</td>
<td>22.22</td>
<td>19.23</td>
<td>20.75</td>
</tr>
<tr>
<td>Total Primary Level*</td>
<td>25.93</td>
<td>30.77</td>
<td>28.30</td>
</tr>
<tr>
<td>Secondary Year 1</td>
<td>0.00</td>
<td>3.85</td>
<td>1.89</td>
</tr>
<tr>
<td>Secondary Year 2</td>
<td>7.41</td>
<td>15.38</td>
<td>11.32</td>
</tr>
<tr>
<td>Secondary Year 3</td>
<td>40.74</td>
<td>7.69</td>
<td>24.53</td>
</tr>
<tr>
<td>Total Secondary Level**</td>
<td>48.15</td>
<td>26.92</td>
<td>37.74</td>
</tr>
<tr>
<td>Tertiary Degree</td>
<td>3.70</td>
<td>3.85</td>
<td>3.77</td>
</tr>
<tr>
<td>Certificate/ Diploma</td>
<td>14.81</td>
<td>3.85</td>
<td>9.43</td>
</tr>
<tr>
<td>Total Graduate Level**</td>
<td>18.52</td>
<td>7.69</td>
<td>13.21</td>
</tr>
</tbody>
</table>

\*\(p<.05\), **\(p<.01\), ***\(p<.001\)
Table 15

*Descriptive Statistics and Normality Tests by Gender for Dependent Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Gender</th>
<th>M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>Skewness Statistic</th>
<th>Standard Error</th>
<th>Skewness-Z*</th>
</tr>
</thead>
<tbody>
<tr>
<td>BN: Total Score</td>
<td>Male</td>
<td>7.29</td>
<td>2.22</td>
<td>2.00</td>
<td>12.00</td>
<td>-0.25</td>
<td>0.45</td>
<td>-0.56</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>6.21</td>
<td>2.42</td>
<td>3.00</td>
<td>13.00</td>
<td>1.03</td>
<td>0.46</td>
<td>2.26</td>
</tr>
<tr>
<td>PSS: Total Score</td>
<td>Male</td>
<td>21.15</td>
<td>7.00</td>
<td>-4.00</td>
<td>28.00</td>
<td>1.97</td>
<td>0.45</td>
<td>-4.40*</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>23.04</td>
<td>4.62</td>
<td>8.00</td>
<td>28.00</td>
<td>-1.62</td>
<td>0.46</td>
<td>-3.55*</td>
</tr>
<tr>
<td>AS: Total Score</td>
<td>Male</td>
<td>7.41</td>
<td>4.20</td>
<td>0</td>
<td>16.00</td>
<td>0.23</td>
<td>0.45</td>
<td>0.50</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>11.81</td>
<td>4.29</td>
<td>4.00</td>
<td>19.00</td>
<td>-0.15</td>
<td>0.46</td>
<td>-0.32</td>
</tr>
<tr>
<td>HTQ: Total Score</td>
<td>Male</td>
<td>25.67</td>
<td>18.74</td>
<td>0</td>
<td>62.00</td>
<td>0.41</td>
<td>0.45</td>
<td>0.91</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>40.58</td>
<td>26.36</td>
<td>1.00</td>
<td>99.00</td>
<td>0.50</td>
<td>0.46</td>
<td>1.10</td>
</tr>
<tr>
<td>HSCL: Total Score</td>
<td>Male</td>
<td>12.41</td>
<td>11.68</td>
<td>0</td>
<td>45.00</td>
<td>0.50</td>
<td>0.46</td>
<td>1.10</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>24.38</td>
<td>17.55</td>
<td>1.00</td>
<td>65.00</td>
<td>0.69</td>
<td>0.46</td>
<td>1.52</td>
</tr>
</tbody>
</table>

Note. BN=Basic Needs; PSS=Perceived Social Support; AS=Acculturative Stress; HTQ=Harvard Trauma Questionnaire; HSCL-25=Hopkins Symptom Checklist-25

*Skewness-Z statistic where values above or below +/- 3.29 = significant skewness (Tabachnic & Fidell, 2007)*
During the ANOVA preliminary assumptions testing processes, distribution for both men and women in the sample group were found to be significantly negatively skewed on the Total Perceived Social Support Total Scores (refer to Table 15 above). Also, two outliers (one man and one woman) with extremely low scores on the perceived social support measure were identified. However, due to the small sample size and minimal change to the Mean scores when the outliers were removed from the data set, these cases were retained for the proceeding ANOVA tests (Pallant, 2007). There were no multivariate normality assumption violations, which was assessed using Mahalanobis distances (Mahalanobis distance = 19.85) and a critical value of 20.52, based on the five dependent variables (Tabachnick & Fidell, 2007). There were no violations of multivariate outliers, covariance or multicollinearity, however the HSCL-25 measure violated the equal variances assumption \( F(1,51)=4.21, p<.05 \) justifying a more stringent alpha level \( p<.01 \) in the univariate analyses (Tabachnick & Fidell). The ANOVA results for each of the dependent variables are presented in Table 16.

Table 16

Univariate Results for Basic Needs, Social Support, Acculturative Stress and Mental Health by Gender

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>( F )</th>
<th>( \text{Sig.} )</th>
<th>( \eta^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Needs: Total Score</td>
<td>2.86</td>
<td>.09</td>
<td>.05</td>
</tr>
<tr>
<td>Perceived Social Support: Total Score</td>
<td>1.33</td>
<td>.25</td>
<td>.02</td>
</tr>
<tr>
<td>Acculturative Stress: Total Score</td>
<td>14.24</td>
<td>.00***</td>
<td>.22</td>
</tr>
<tr>
<td>Harvard Trauma Questionnaire: Total Score</td>
<td>5.67</td>
<td>.02*</td>
<td>.10</td>
</tr>
<tr>
<td>Hopkins Symptom Checklist-25: Total Score</td>
<td>8.61</td>
<td>.00**</td>
<td>.14</td>
</tr>
</tbody>
</table>

\( N=53 \)

\(*p<.05, **p<.01, p<.001\)
Table 16 indicates that men and women significantly differed on their acculturative stress and mental health scores (as reflected from the HTQ and HSCL-25 total scores). Based on the pattern of mean scores for each measure (refer to Table 15) women tended to show higher scores on each measure than men, suggesting that women in the current sample group reported significantly higher acculturative stress, symptoms of trauma, anxiety and depression and consequently, lower mental wellbeing than men. The effect sizes further suggested that these differences were considerable, with 22% of the variance in acculturative stress scores, 10% of the variance in HTQ scores and 14% of the variances in the HSCL-25 scores being attributable to gender differences.

5.1.2 The influence of age on basic needs, social support, acculturative stress and mental health

Participants’ ages ranged from 20 years to 50 years ($M=33.67$, $SD=8.01$ years). The data was explored to ascertain if age was related to participants’ access to basic needs and their reported scores on each of subscales and total scores for perceived social support, acculturative stress, HTQ and HSCL-25. Pearson’s correlations were used to examine these relationships; the results of which are provided in Table 17.
Table 17

Descriptive Statistics and Pearson’s Correlations of the Research Variables and Age

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>N</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>33.67</td>
<td>8.01</td>
<td>53</td>
<td>-</td>
</tr>
<tr>
<td>BN: Meals per day</td>
<td>1.85</td>
<td>.35</td>
<td>49</td>
<td>-.12</td>
</tr>
<tr>
<td>BN: Common experiences of hunger</td>
<td>.16</td>
<td>.37</td>
<td>49</td>
<td>-.02</td>
</tr>
<tr>
<td>BN: Access to water</td>
<td>.74</td>
<td>.67</td>
<td>47</td>
<td>-.17</td>
</tr>
<tr>
<td>BN: Type of housing</td>
<td>1.35</td>
<td>.48</td>
<td>51</td>
<td>-.00</td>
</tr>
<tr>
<td>BN: Access to health care</td>
<td>.56</td>
<td>.94</td>
<td>48</td>
<td>-.08</td>
</tr>
<tr>
<td>BN: Educational Attainment</td>
<td>1.55</td>
<td>1.15</td>
<td>53</td>
<td>.19</td>
</tr>
<tr>
<td>BN: Steady employment</td>
<td>.36</td>
<td>.48</td>
<td>52</td>
<td>.38**</td>
</tr>
<tr>
<td>BN: Total Score</td>
<td>6.76</td>
<td>2.36</td>
<td>53</td>
<td>.05</td>
</tr>
<tr>
<td>PSS: Family subscale</td>
<td>10.52</td>
<td>4.57</td>
<td>53</td>
<td>-.15</td>
</tr>
<tr>
<td>PSS: Friends subscale</td>
<td>11.54</td>
<td>2.65</td>
<td>53</td>
<td>-.04</td>
</tr>
<tr>
<td>PSS: Total score</td>
<td>22.08</td>
<td>5.98</td>
<td>53</td>
<td>-.14</td>
</tr>
<tr>
<td>Acculturative Stress: Somatic symptoms</td>
<td>4.90</td>
<td>2.84</td>
<td>53</td>
<td>-.10</td>
</tr>
<tr>
<td>Acculturative stress: Psychological symptoms</td>
<td>4.66</td>
<td>2.52</td>
<td>53</td>
<td>-.47***</td>
</tr>
<tr>
<td>Acculturative stress: Total score</td>
<td>9.56</td>
<td>4.75</td>
<td>53</td>
<td>-.31*</td>
</tr>
<tr>
<td>HTQ: PTSD symptoms</td>
<td>13.58</td>
<td>10.17</td>
<td>53</td>
<td>-.26</td>
</tr>
<tr>
<td>HTQ: Other impairment symptoms</td>
<td>19.39</td>
<td>14.55</td>
<td>53</td>
<td>-.38**</td>
</tr>
<tr>
<td>HTQ: Total score</td>
<td>32.98</td>
<td>23.79</td>
<td>53</td>
<td>-.34*</td>
</tr>
<tr>
<td>HSCL-25: Anxiety symptoms</td>
<td>6.56</td>
<td>6.50</td>
<td>53</td>
<td>-.33*</td>
</tr>
<tr>
<td>HSCL-25: Depression symptoms</td>
<td>11.71</td>
<td>9.90</td>
<td>53</td>
<td>-.28*</td>
</tr>
<tr>
<td>HSCL-25: Total score</td>
<td>18.23</td>
<td>15.90</td>
<td>53</td>
<td>-.31*</td>
</tr>
</tbody>
</table>

Note. BN=Basic Needs; PSS=Perceived Social Support; HTQ=Harvard Trauma Questionnaire; PTSD=Posttraumatic Stress Disorder; HSCL-25=Hopkins Symptom Checklist-25;* p <.05; ** p <.01; *** p <.001

As shown in Table 17, the correlations analysis revealed that in the basic needs measures, age only appeared to be significantly and moderately related to participants’ access to steady employment, with older participants tending to have greater access to employment.
There was no relationship between age and Basic Needs Total Scores, or for participants’ Perceived Social Support. In the measure of acculturative stress, age was not related to somatic complaints, but there was a moderately negative and significant relationship between age and acculturative stress psychological symptoms and subsequently, the total acculturative stress scores. In a similar pattern, age did not impact symptoms of posttraumatic stress disorder on the HTQ, but was moderately negatively related to experiences of other impairment as reported on that scale. Age was also found to be moderately, negatively and significantly related to the subscales and total scores of the HSCL-25. In all significant relationships found between age and measures on acculturative stress, the HTQ and the HSCL-25, the negative correlation indicated that younger people tended to experience greater symptoms on all measures; or conversely, that higher age appeared to be a protector of mental wellbeing.

5.1.3 The influence of education attained on social support, acculturative stress and mental health

As part of the data screening process (refer to Chapter 4.1) a moderately positive and significant relationship was shown for people with higher education and better access to health care ($r_s=-.35, n=52, p<.05$) and steady employment ($r_s=-.35, n=52, p<.01$). Previous gender analyses also revealed that men in the current sample group had attained higher levels of education than women ($t(51)=3.08, p<.01$). For a full breakdown of education by host/returnee groups and gender, refer to Table 2 in Chapter 4.1 (p.88). However, to briefly summarise, 20.8% of the total sample group had received no education at all, most of whom were women. The most frequently reported level of educational attainment was completion of secondary school (24.5%) and less than 4% of the total sample had obtained a tertiary-level education.
As the education scores were coded on a continuous scale (see Chapter 4.1 Participants, p.81), an initial correlation analysis was conducted for educational attainment and scores on the perceived social support, acculturative stress, trauma (HTQ) and depression and anxiety (HSCL-25) measures (subscales and total scores). These correlations are presented in Table 18. The Basic Needs Total Score was excluded from the analysis because education itself was measured as part of that scale and its relationship to other aspects of basic needs had already been determined.

Table 18 shows that there were significant relationships between educational attainment and acculturative stress, symptoms of trauma based on the HTQ and symptoms of depression and anxiety, based on the HSCL-25. In all significant relationships, higher education correlated with lower scores on acculturative stress, the HTQ and HSCL-25, suggesting that people with higher educational attainment may be more protected from the symptoms of acculturative stress, trauma, depression and anxiety.

Given a relationship was evident between education and acculturative stress and mental health, and descriptive statistics indicated that many of the participants had either received no education at all (20.8%) or had only completed a basic primary education (28%, n=53), the question of whether or not the actual level of education completed influenced the correlation of higher education being linked to greater mental health and wellbeing was considered. To investigate this, a one-way Multivariate Analysis of Variance (MANOVA) was performed using the levels of educational attainment as the independent variable and the Acculturative Stress, HTQ and HSCL-25 Total Scores as the dependent variables. Following confirmation that the assumptions of multivariate analysis were met, MANOVA showed no significant differences between the levels of education completed and mental wellbeing total scores ($F(4,28)=1.12, p>.05$). Therefore, although the correlation analyses showed a pattern of higher education being related to higher mental health and wellbeing, this was not determined
by what actual level of education was achieved. This further suggests that for people living in South Sudan, any formal education, regardless of the level attained, is likely to contribute to improved wellbeing.

Table 18

*Correlation Analysis of Educational Attainment and Perceived Social Support, Acculturative Stress and Mental Health*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>BN: Educational Attainment</td>
<td>53</td>
<td>1.56</td>
<td>1.15</td>
<td>-.</td>
</tr>
<tr>
<td>PSS: Family subscale</td>
<td>53</td>
<td>10.52</td>
<td>4.57</td>
<td>-.21</td>
</tr>
<tr>
<td>PSS: Friends subscale</td>
<td>53</td>
<td>11.54</td>
<td>2.65</td>
<td>-.21</td>
</tr>
<tr>
<td>PSS: Total score</td>
<td>53</td>
<td>22.07</td>
<td>5.98</td>
<td>-.25</td>
</tr>
<tr>
<td>Acculturative Stress: Somatic symptoms</td>
<td>53</td>
<td>4.90</td>
<td>2.84</td>
<td>-.23</td>
</tr>
<tr>
<td>Acculturative stress: Psychological symptoms</td>
<td>53</td>
<td>4.66</td>
<td>2.52</td>
<td>-.36**</td>
</tr>
<tr>
<td>Acculturative stress: Total score</td>
<td>53</td>
<td>9.56</td>
<td>4.75</td>
<td>-.35**</td>
</tr>
<tr>
<td>HTQ: PTSD symptoms</td>
<td>53</td>
<td>13.58</td>
<td>10.17</td>
<td>-.34*</td>
</tr>
<tr>
<td>HTQ: Other impairment symptoms</td>
<td>53</td>
<td>19.34</td>
<td>14.55</td>
<td>-.39**</td>
</tr>
<tr>
<td>HTQ: Total score</td>
<td>53</td>
<td>32.98</td>
<td>23.79</td>
<td>-.38**</td>
</tr>
<tr>
<td>HSCL-25: Anxiety symptoms</td>
<td>53</td>
<td>6.56</td>
<td>6.50</td>
<td>-.35**</td>
</tr>
<tr>
<td>HSCL-25: Depression symptoms</td>
<td>53</td>
<td>11.71</td>
<td>9.90</td>
<td>-.45**</td>
</tr>
<tr>
<td>HSCL-25: Total score</td>
<td>53</td>
<td>18.28</td>
<td>15.90</td>
<td>-.42**</td>
</tr>
</tbody>
</table>

Note. BN=Basic Needs; PSS=Perceived Social Support; HTQ=Harvard Trauma Questionnaire; PTSD=Posttraumatic Stress Disorder; HSCL-25=Hopkins Symptom Checklist-25; * p<.05; ** p<.01
5.1.4 The influence of marital status on basic needs, social support, acculturative stress and mental health

As briefly described in Chapter 4.1, more than half of the total sample reported being married (69.8%, \(N=37\)). Other marital categories included being unmarried, widowed, separated or inherited. The Participants chapter outlined the differences in marital status by the host and returnee sample groups, whereas Table 19 provides a revised summary of the marital status of the total sample group by gender, which shows that only women were widowed or inherited and only men in the sample group reported being unmarried.

Table 19

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Women</th>
<th>Men</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N)</td>
<td>% of women</td>
<td>(N)</td>
</tr>
<tr>
<td>Married</td>
<td>17</td>
<td>65.38</td>
<td>20</td>
</tr>
<tr>
<td>Not married</td>
<td>-</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>11.54</td>
<td>-</td>
</tr>
<tr>
<td>Inherited</td>
<td>3</td>
<td>11.54</td>
<td>-</td>
</tr>
<tr>
<td>Separated</td>
<td>3</td>
<td>11.54</td>
<td>3</td>
</tr>
</tbody>
</table>

Due to the small sample size and small numbers in some of the marital status categories, the marital status data was minimised to two marital status categories for further analysis. The revised marital status categories were: (1) Married \((n=37)\); and (2) Without Partner \((n=16\); consisting of participants in the sample who were not married, widowed and inherited or separated). Independent samples t-tests did not reveal any significant differences (at \(p<.05\)) between participants who were married or without a partner on their mean scores.
for any of the subscales or total scores on the basic needs, perceived social support, acculturative stress, HTQ or HSCL-25 measures. Therefore, in this sample, marital status did not appear to influence the participants’ reports on any of the other measures being studied.

5.1.5 The influence of employment status on basic needs, social support, acculturative stress and mental health

In the total sample, 35.8% of participants reported having access to steady employment. To determine if steady employment (scored as 1=yes; 2=no) was related to other variables in the study, Pearson correlations were computed and results are presented in Table 20.

Table 20 shows that employment status was not significantly related to most of the basic needs variables, with the exception of a low but significant relationship with education. That is to say that people in the sample group who had access to steady employment tended to also have higher levels of educational attainment. In addition, the findings showed a statistically significant, moderate negative correlation between people with steady employment who appeared to report fewer symptoms of acculturative stress, trauma as per the HTQ and depression and anxiety as per symptoms reported on the HSCL-25. There was no relationship between employment status and perceived social support.
Table 20
Pearson’s Correlations Between Steady Employment and Access to Basic Needs, Social Support, Acculturative Stress and Mental Health

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Steady Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>BN: Steady Employment Score</td>
<td>52</td>
<td>-</td>
</tr>
<tr>
<td>BN: Meals per Day Score</td>
<td>49</td>
<td>-.05</td>
</tr>
<tr>
<td>BN: Hunger Score</td>
<td>49</td>
<td>-.10</td>
</tr>
<tr>
<td>BN: Access to Water Score</td>
<td>47</td>
<td>-.24</td>
</tr>
<tr>
<td>BN: Type of Housing Score</td>
<td>51</td>
<td>.05</td>
</tr>
<tr>
<td>BN: Access to Health Care Score</td>
<td>48</td>
<td>.06</td>
</tr>
<tr>
<td>BN: Educational Attainment Score</td>
<td>52</td>
<td>.33*</td>
</tr>
<tr>
<td>BN: Total Score</td>
<td>52</td>
<td>.34*</td>
</tr>
<tr>
<td>PSS: Family Subscale (15-items)</td>
<td>52</td>
<td>-.04</td>
</tr>
<tr>
<td>PSS: Friends Subscale (13-items)</td>
<td>52</td>
<td>-.12</td>
</tr>
<tr>
<td>PSS: Total Score (28-items)</td>
<td>52</td>
<td>-.08</td>
</tr>
<tr>
<td>AS: Somatic Symptoms</td>
<td>52</td>
<td>-.19</td>
</tr>
<tr>
<td>AS: Psychological Symptoms</td>
<td>52</td>
<td>-.39**</td>
</tr>
<tr>
<td>AS: Total Score</td>
<td>52</td>
<td>-.32*</td>
</tr>
<tr>
<td>HTQ: DSM Symptoms</td>
<td>52</td>
<td>-.34**</td>
</tr>
<tr>
<td>HTQ: Other Impairment Symptoms</td>
<td>52</td>
<td>-.37**</td>
</tr>
<tr>
<td>HTQ: Total Score</td>
<td>52</td>
<td>-.39**</td>
</tr>
<tr>
<td>HSCL: Anxiety Symptoms</td>
<td>52</td>
<td>-.23*</td>
</tr>
<tr>
<td>HSCL: Depression Symptoms</td>
<td>52</td>
<td>-.34*</td>
</tr>
<tr>
<td>HSCL: Total Score</td>
<td>52</td>
<td>-.33*</td>
</tr>
</tbody>
</table>

Note. BN=Basic Needs; PSS=Perceived Social Support; AS=Acculturative Stress; HTQ=Harvard Trauma Questionnaire; HSCL=Hopkins Symptom Checklist-25. *p<.05, **p<.01

To further verify likely differences between participants with steady employment and those without, the variables with significant correlations to employment status were then
analysed using independent samples t-tests. Table 21 shows the results of these analyses which confirmed that people without steady employment scored significantly lower on education attainment ($t(50)=2.54, p<.05$) and their overall access to basic needs ($t(50)=2.57, p<.05$). They also scored significantly higher than their employed counterparts on the symptoms and total scores of the Acculturative Stress Scale ($t(50)=-2.44, p<.05$), the HTQ ($t(50)=-3.00, p<.05$) and the HSCL-25 ($t(50)=-2.54, p<.05$). Therefore, the current sample showed that having higher educational attainment and access to steady employment also linked to having greater access to basic needs and lower symptoms of acculturative stress, trauma, depression and anxiety, and thus overall greater mental wellbeing.
Table 21

Descriptive Statistics and t-tests by Employment Status for Basic Needs, Acculturative Stress, HTQ and HSCL-25 Subscales and Total Scores

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Employment Status: Yes</th>
<th>Employment Status: No</th>
<th>Employment Status differences</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>BN: Education attainment</td>
<td>19</td>
<td>2.07</td>
<td>1.15</td>
<td>33</td>
</tr>
<tr>
<td>BN: Total Score</td>
<td>19</td>
<td>7.83</td>
<td>2.58</td>
<td>33</td>
</tr>
<tr>
<td>AS: Somatic symptoms</td>
<td>19</td>
<td>4.26</td>
<td>2.84</td>
<td>33</td>
</tr>
<tr>
<td>AS: Psychological symptoms</td>
<td>19</td>
<td>3.42</td>
<td>2.34</td>
<td>33</td>
</tr>
<tr>
<td>AS: Total score</td>
<td>19</td>
<td>7.68</td>
<td>4.63</td>
<td>33</td>
</tr>
<tr>
<td>HTQ: PTSD symptoms</td>
<td>19</td>
<td>8.57</td>
<td>6.89</td>
<td>33</td>
</tr>
<tr>
<td>HTQ: Other impairment symptoms</td>
<td>19</td>
<td>12.63</td>
<td>11.31</td>
<td>33</td>
</tr>
<tr>
<td>HTQ: Total score</td>
<td>19</td>
<td>21.21</td>
<td>17.64</td>
<td>33</td>
</tr>
<tr>
<td>HSCL-25: Anxiety symptoms</td>
<td>19</td>
<td>4.15</td>
<td>5.30</td>
<td>33</td>
</tr>
<tr>
<td>HSCL-25: Depression symptoms</td>
<td>19</td>
<td>7.31</td>
<td>7.14</td>
<td>33</td>
</tr>
<tr>
<td>HSCL-25: Total score</td>
<td>19</td>
<td>11.47</td>
<td>11.91</td>
<td>33</td>
</tr>
</tbody>
</table>

Note. BN=Basic Needs; AS=Acculturative Stress; HTQ=Harvard Trauma Questionnaire; PTSD=Posttraumatic Stress Disorder; HSCL-25=Hopkins Symptom Checklist-25

* Equal variances not assumed; * p<.05; ** p<.01
5.1.6 Summary and post hoc analyses of preliminary quantitative findings

The preliminary quantitative analyses revealed a range of factors that influenced the respondents’ mental health and wellbeing. Age was associated with greater access to employment and overall mental wellbeing, while marital status did not influence any of the measures studied. A series of significant gender difference were found: women were significantly lower than men on all wellbeing measures and they also reported significantly lower levels of educational attainment than men. Lower education was related to having less access to health care, steady employment and overall basic needs. Furthermore, people in the group with lower levels of educational attainment showed higher scores on each of the wellbeing measures (acculturative stress, HTQ and HSCL-25) indicating that lower education was related to lower mental wellbeing. Employment was another protector for wellbeing with steady employment being significantly linked to higher wellbeing scores.

As the preliminary analyses exposed various links between gender, education, employment and wellbeing, a post hoc analysis looking at these specific variables was implemented. To ascertain if the relationship between gender and mental wellbeing were additionally influenced by education and employment status, three standard multiple regression analyses were performed. Gender, educational attainment and employment status were used as the independent measures and mental wellbeing as the dependent variables. Given the preliminary analyses and relationships between gender, education and employment for each of the acculturative stress, HTQ and HSCL-25 subscales revealed varying outcomes of significance, only the total scores of the these three measures were used. As a first step, Pearson correlations of the variables to be analysed were computed and are presented in Table 22.
**Table 22**

Pearson’s Correlations Showing Relationships Between Gender, Educational Attainment, Employment Status and Acculturative Stress and Mental Health Total Scores

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>r</td>
<td>R</td>
<td>r</td>
</tr>
<tr>
<td>1. Gender</td>
<td>53</td>
<td>1.49</td>
<td>.50</td>
<td>-.39**</td>
<td>-.04</td>
<td>.47**</td>
</tr>
<tr>
<td>2. Educational attainment</td>
<td>53</td>
<td>1.56</td>
<td>1.15</td>
<td>.34*</td>
<td>.33*</td>
<td>-.33**</td>
</tr>
<tr>
<td>3. Employment status</td>
<td>52</td>
<td>.36</td>
<td>.48</td>
<td>-.32*</td>
<td>-.39**</td>
<td>-.33*</td>
</tr>
<tr>
<td>4. AS: Total score</td>
<td>53</td>
<td>9.56</td>
<td>4.75</td>
<td>.67**</td>
<td>.71**</td>
<td></td>
</tr>
<tr>
<td>5. HTQ: Total score</td>
<td>53</td>
<td>32.98</td>
<td>23.79</td>
<td>.91**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. HSCL: Total score</td>
<td>53</td>
<td>18.28</td>
<td>15.90</td>
<td>-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. AS=Acculturative Stress; HTQ=Harvard Trauma Questionnaire; HSCL=Hopkins Symptom Checklist-25. *p<.05, **p<.01

Table 22 shows that the only non-significant relationship amongst the variables is between gender and employment status ($r=-.04, n=53, p>.05$), with men and women appearing to have similar access to steady employment. However, since women had significantly lower education than men and this gender and education relation was significant – plus the finding that education and employment status were significantly related – this justified the inclusion of both employment and education within the regression analysis.

After ensuring no violations for the multiple regression assumptions, a standard regression analysis was performed. For the Acculturative Stress Total Scores, the combination of gender, educational attainment and employment status contributed significantly to the total scores ($F(3,48)=7.41, R^2=.31, p<.001$), which was a similar finding for the HTQ Total Scores.
\( F(3,48)=5.85, R^2=.26, p<.01 \) and the HSCL-25 Total Scores \( F(2,48)=6.47, R^2=.29, p<.01 \). Thus, 31% of the variance in the Acculturative Stress Total Scores, 26% of the variance in HTQ Total Scores and 29% of the variance in HSCL-25 Total Scores could be attributed to the combined contributions of the independent variables – gender, educational attainment and employment status. However, the standardised beta weights shown in Table 23 reveal that the unique contribution of the independent variables was different for each dependent variable.

Table 23 shows that gender was the strongest predictor of acculturative stress and HSCL-25 total scores, but employment status was the only statistically significant and unique contributor to the variation in HTQ scores. Interestingly, on its own, educational attainment did not contribute significantly to any of the acculturative stress, HTQ or HSCL-25 total scores. Therefore, the relationship between education and acculturative stress suggested by the correlation analysis (refer to correlations Table 22), was explained by gender and employment status. Also, these regression results further confirm that gender alone is likely to predict higher scores, and thus lower mental wellbeing, for acculturative stress and HSCL-25 anxiety and depression symptoms, but not HTQ trauma and other impairment symptoms, where employment appears to be the biggest predictor.

In summary, it appears from this regression model, that the relationship of women having less education than men and potentially less employment as a consequence, is not necessarily associated with the wellbeing measures. Subsequently, differences in gender, educational attainment and access to employment, and how they relate to wellbeing, will be best managed separately rather than all being connected as a flow-on effect. Additionally, the small sample size may have influenced the betas and thus any generalisability of the regression findings should be utilised with caution.
Table 23

Regression Analysis Showing the Unique Contributions of Gender, Education and Employment Status on Acculturative Stress, HTQ and HSCL-25 Total Scores

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Unstandardised Coefficients</th>
<th>Standardised Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
</tr>
<tr>
<td>Independent Variable: Gender (F(3,48)=7.41, R^2=.31, p&lt;.001)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acculturative Stress Total Scores</td>
<td>4.04</td>
<td>1.23</td>
</tr>
<tr>
<td>HTQ Total Scores</td>
<td>10.87</td>
<td>6.38</td>
</tr>
<tr>
<td>HSCL-25 Total Scores</td>
<td>8.79</td>
<td>4.20</td>
</tr>
<tr>
<td>Independent Variable: Education (F(3,48)=5.85, R^2=.51, p&lt;.01)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acculturative Stress Total Scores</td>
<td>-.28</td>
<td>.57</td>
</tr>
<tr>
<td>HTQ Total Scores</td>
<td>-3.80</td>
<td>2.97</td>
</tr>
<tr>
<td>HSCL-25 Total Scores</td>
<td>-3.18</td>
<td>1.96</td>
</tr>
<tr>
<td>Independent Variable: Employment Status (F(3,48)=6.47, R^2=.53, p&lt;.001)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acculturative Stress Total Scores</td>
<td>-2.80</td>
<td>1.27</td>
</tr>
<tr>
<td>HTQ Total Scores</td>
<td>-15.60</td>
<td>6.46</td>
</tr>
<tr>
<td>HSCL-25 Total Scores</td>
<td>-8.15</td>
<td>4.25</td>
</tr>
</tbody>
</table>

Note. HTQ=Harvard Trauma Questionnaire; HSCL-25=Hopkins Symptom Checklist.

* p<.05, ** p<.01, *** p<.001

5.2 Hypothesis 1 results

The first hypothesis looked at the sample group as a whole. It was expected that higher access to basic needs, higher perceived social support and low acculturative stress would be associated with higher mental health outcomes, as represented by low scores on the
Harvard Trauma Questionnaire (HTQ) and Hopkins Symptom Checklist-25 (HSCL-25). It was also predicted that basic needs, followed by perceived social support would be the prominent predictors of mental health, with acculturative stress only minimally contributing to mental health. To assess the strength and order of those relationships a hierarchical multiple regression analysis was performed, using Basic Needs, Perceived Social Support and Acculturative Stress as the independent variables with the HTQ and HSCL-25 measures as the dependent variables.

First, to glean an overall picture of the variables and test some of the regression assumptions, Table 24 shows the means and standard deviations for each measure, as well as how all the variables correlate with each other. A thorough examination of the basic needs subscales (meals per day, common experiences of hunger, access to clean water, type of housing, access to health care, highest level of education attained and steady employment) and their inter-item correlations was reported in Chapter 4.3.3, Table 4. Also, the preliminary exploratory analyses had already demonstrated significant relationships between mental health and the basic needs variables of gender, age, education and employment status. Therefore, Table 24 only reports on correlations for the Basic Needs Total Score, in addition to the other perceived social support, acculturative stress, HTQ and HSCL-25 subscales and total scores.
Table 24

*Descriptive Statistics and Pearson’s Correlations for Basic Needs, Social Support, Acculturative Stress and Mental Health*

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BN: Total score</td>
<td>6.76</td>
<td>2.36</td>
<td>-.13</td>
<td>-.16</td>
<td>-.17</td>
<td>-.22</td>
<td>- .35**</td>
<td>-.32*</td>
<td>-.37**</td>
<td>-.43***</td>
<td>-.42***</td>
<td>-.34*</td>
<td>.46***</td>
<td>-.42***</td>
</tr>
<tr>
<td>2</td>
<td>PSS: Family subscale (15-items)</td>
<td>10.53</td>
<td>4.58</td>
<td>.32*</td>
<td>.91***</td>
<td>-.15</td>
<td>-.11</td>
<td>-.14</td>
<td>-.09</td>
<td>-.07</td>
<td>-.08</td>
<td>-.07</td>
<td>-.09</td>
<td>-.09</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>PSS: Friends subscale (13-items)</td>
<td>11.55</td>
<td>2.65</td>
<td>.67***</td>
<td>.04</td>
<td>.11</td>
<td>.08</td>
<td>.07</td>
<td>.04</td>
<td>.06</td>
<td>.15</td>
<td>.10</td>
<td>.12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>PSS: Total score (28-items)</td>
<td>22.08</td>
<td>5.97</td>
<td>-.10</td>
<td>-.03</td>
<td>-.07</td>
<td>-.04</td>
<td>-.04</td>
<td>-.04</td>
<td>-.01</td>
<td>-.03</td>
<td>-.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>AS: Somatic symptoms</td>
<td>4.91</td>
<td>2.84</td>
<td></td>
<td>.56***</td>
<td>.90***</td>
<td>.44***</td>
<td>.48***</td>
<td>.48***</td>
<td>.62***</td>
<td>.52***</td>
<td>.58***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>AS: Psychological symptoms</td>
<td>4.66</td>
<td>2.53</td>
<td></td>
<td>.87***</td>
<td>.62***</td>
<td>.75***</td>
<td>.72***</td>
<td>.71***</td>
<td>.64***</td>
<td>.68***</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>AS: Total score</td>
<td>9.57</td>
<td>4.75</td>
<td></td>
<td>.59***</td>
<td>.69***</td>
<td>.67***</td>
<td>.75***</td>
<td>.65***</td>
<td>.71***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>HTQ: PTSD symptoms</td>
<td>13.58</td>
<td>10.17</td>
<td></td>
<td>.84***</td>
<td>.94***</td>
<td>.79***</td>
<td>.81***</td>
<td>.83***</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9</td>
<td>HTQ: Other impairment symptoms</td>
<td>19.40</td>
<td>14.55</td>
<td></td>
<td>.97***</td>
<td>.87***</td>
<td>.89***</td>
<td>.91***</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>HTQ: Total score</td>
<td>32.98</td>
<td>23.80</td>
<td></td>
<td>.87***</td>
<td>.89***</td>
<td>.91***</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>HSCL: Anxiety symptoms</td>
<td>6.57</td>
<td>6.51</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.87***</td>
<td>.95***</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>HSCL: Depression symptoms</td>
<td>11.72</td>
<td>9.90</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.98***</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>HSCL: Total score</td>
<td>18.28</td>
<td>15.90</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

*N=53. BN=Basic Needs; PSS=Perceived Social Support; HTQ=Harvard Trauma Questionnaire; PTSD=Posttraumatic Stress Disorder; HSCL-25=Hopkins Symptom Checklist-25; *p <.05; **p<.01; p<.001*
As part of checking the assumptions for the hierarchical multiple regression model, the correlations presented in Table 24 were carefully examined. The correlations analyses showed that the independent measure of perceived social support from family, friends and the total perceived social support scores did not significantly correlate with any of the other independent measures (basic needs or acculturative stress), but in addition, they did not correlate with the subscales or total scores of the dependent variables – the HTQ or HSCL-25. As a result of this non-significant relationship between the independent variable of perceived social support and the HTQ and HSCL-25, perceived social support was excluded from the subsequent hierarchical regression hypothesis testing procedures.

When further analysing the correlations of the independent measures for potential multicollinearity, the basic needs total scores did not correlate with the acculturative stress somatic symptoms subscale, but they did show a moderate, negative and significant relationship to the acculturative stress psychological symptoms subscale ($r = -.35, n=53, p<.01$) and subsequently, with the acculturative stress total score ($r = -.32, n=53, p<.05$). However, since none of the correlations between the intended independent variables exceeded .70 (Pallant, 2007), there were no violations of the assumption of multicollinearity. Thus the multiple regression tests proceeded to use both the basic needs and the acculturative stress total scores as the independent variables.

The correlation analysis (Table 24) also revealed a moderate, negative and significant relationship between the basic needs total scores and the HTQ trauma symptoms subscale ($r = .37, n=53, p<.01$), the other impairment subscale ($r = -.42, n=53, p<.001$) and HTQ total score ($r = -.42, n=53, p<.001$); as well as the symptoms of anxiety ($r = -.34, n=53, p<.05$) and depression ($r = -.46, n=53, p<.001$) of the HSCL-25 and its total score ($r = -.42, n=53, p<.001$). These relationships suggest that participants with less access to basic needs tended to experience higher symptoms of trauma, depression and anxiety, thus poorer mental
wellbeing. It was therefore confirmed that all of the HTQ and HSCL-25 subscales and total scores would be maintained as the dependent measures for the regression analysis, which was also deemed important given the uniqueness of the sample group.

In summary, the correlation analysis revealed that in the current sample and with the measures utilised in the study, only basic needs and acculturative stress were significantly associated with mental health and wellbeing (based on the HTQ and HSCL-25 subscales and total scores). Perceived social support was not significantly related to the dependent measures and was therefore excluded from the regression model. Also, to ensure the assumptions for multiple regressions were met, the independent variables for the regression analysis were reduced to two measures; the basic needs total scores and acculturative stress total scores. The HTQ and HSCL-25 subscales and total scores remained unchanged as the dependent variables in the model.

In a further assessment of the multiple regression statistical assumptions, normal distribution, linearity, homoscedasticity and independence of residuals were not violated. There were no univariate outliers observed in the independent measures (i.e.: Mahalanobis distances were all well below the critical value), but one univariate outlier was identified with high HTQ and HSCL-25 subscale and total scores. An individual assessment of this univariate outlier was undertaken and on the basis of that individual’s gender, life circumstances and presentation throughout the interviews, it was deemed that these high scores were feasible. Therefore, given the likely outcome that this case would report high HTQ and HSCL-25 scores, and the need to be as inclusive as possible due to the small sample size, the participant’s scores were retained in the analysis.

Drawing on the foundational theories of the current research indicating that mental health derives first and foremost from having access to basic needs and survival resources, followed by family, friend and community social supports (IASC, 2007; Maslow, 1954;
WHO, 2001), the first step of the hierarchical multiple regression analysis entered the basic needs total score to assess its influence for each of the dependent variables: subscales and total scores of the HTQ and HSCL-25. Ideally, the perceived social support measure would have been added to the analysis as the second step, but as previously discussed, this measure was unable to be included in the regression model. Therefore, step two of the hierarchical multiple regression analysis added the acculturative stress total scores to ascertain if this altered the variance of scores on the HTQ and HSCL-25 subscales and total scores. The results from the hierarchical multiple regression analysis are summarised in Table 25.

As summarised in Table 25, the first step of the hierarchical multiple regression showed that basic needs explained 18% of the variance in HTQ total scores as well as 18% of the variance in HSCL-25 total scores. After step two and entry of the acculturative stress total scores, the total variance explained by the model as a whole was 50% for the HTQ total scores ($F(2,50)=25.21, p<.001$) and 55% for the HSCL-25 total scores ($F(2,50)=30.88, p<.001$). Therefore, the acculturative stress total scores made a significant and unique contribution to the HTQ and HSCL-25 total scores; acculturative stress total scores explained an additional 32.5% of the variance in the HTQ total scores ($F_{change} (1,50) = 32.65, p<.001$) and an additional 37.1% of the variance in the HSCL-25 total scores ($F_{change} (1,50)=41.43, p<.001$).
Table 25

Hierarchical Multiple Regression Standardised Results for Basic Needs and Acculturative Stress Predicting Mental Wellbeing

### Step 1. Basic Needs Total Score (IV)

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>( R^2 )</th>
<th>( \Delta R^2 )</th>
<th>( F ) Change</th>
<th>( B )</th>
<th>( S E )</th>
<th>( \beta )</th>
<th>( T )</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTQ: PTSD Symptoms</td>
<td>.14</td>
<td>-</td>
<td>8.23***</td>
<td>-.87</td>
<td>.50</td>
<td>-.20</td>
<td>-1.73</td>
<td>.08</td>
</tr>
<tr>
<td>HTQ: Other Impairment Symptoms</td>
<td>.18</td>
<td>-</td>
<td>11.38***</td>
<td>-1.41</td>
<td>.63</td>
<td>-.23</td>
<td>-2.22</td>
<td>.03*</td>
</tr>
<tr>
<td>HTQ: Total Scores</td>
<td>.17</td>
<td>-</td>
<td>10.96***</td>
<td>-2.29</td>
<td>1.06</td>
<td>-.23</td>
<td>-2.15</td>
<td>.03*</td>
</tr>
<tr>
<td>HSCL-25: Anxiety Symptoms</td>
<td>.12</td>
<td>-</td>
<td>6.76**</td>
<td>-.31</td>
<td>.27</td>
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<td>.21</td>
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<td>.67</td>
<td>-.22</td>
<td>-2.19</td>
<td>.03*</td>
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</table>

### Step 2. Basic Needs and Acculturative Stress Total Scores (IVs)

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>( R^2 )</th>
<th>( \Delta R^2 )</th>
<th>( F ) Change</th>
<th>( B )</th>
<th>Standard Error</th>
<th>( \beta )</th>
<th>( T )</th>
<th>Sig.</th>
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<tbody>
<tr>
<td>HTQ: PTSD Symptoms</td>
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<td>.25</td>
<td>20.54***</td>
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<td>.25</td>
<td>.53</td>
<td>4.53</td>
<td>.00***</td>
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<td>HTQ: Other Impairment Symptoms</td>
<td>.52</td>
<td>.34</td>
<td>35.46***</td>
<td>1.88</td>
<td>.31</td>
<td>.61</td>
<td>5.95</td>
<td>.00***</td>
</tr>
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<td>HTQ: Total Scores</td>
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<td>.32</td>
<td>32.65***</td>
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<td>.60</td>
<td>5.71</td>
<td>.00***</td>
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<td>HSCL-25: Anxiety Symptoms</td>
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<td>.45</td>
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<td>.97</td>
<td>.13</td>
<td>.71</td>
<td>7.29</td>
<td>.00***</td>
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<td>HSCL-25: Depression Symptoms</td>
<td>.49</td>
<td>.29</td>
<td>28.43***</td>
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<td>.22</td>
<td>.56</td>
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<td>.00***</td>
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<td>.33</td>
<td>.55</td>
<td>6.43</td>
<td>.00***</td>
</tr>
</tbody>
</table>

Note. Degrees of freedom for all dependent variables=Step 1 df(1,51); Step 2 df(1,50). HTQ=Harvard Trauma Questionnaire; HSCL-25: Hopkins Symptom Checklist-25. *\( p<.05 \); **\( p<.01 \); ***\( p<.001 \)
In the final hierarchical multiple regression model, the basic needs total score still contributed uniquely and significantly to the HTQ ($\beta = -.23, p < .05$) and HSCL-25 Total Scores ($\beta = -.23, p < .05$) after controlling for acculturative stress. The negative direction of these relationships suggests that people who had less access to basic needs tended to show more symptoms of impairment, trauma, anxiety and depression. However, the acculturative stress total score also contributed significantly and more strongly on all of the subscale and total scores of the HTQ and HSCL-25. Therefore, it appears that in this sample, acculturative stress was the strongest predictor of the mental wellbeing followed by a smaller but significant contribution from basic needs.

The first hypothesis further predicted a mediating relationship whereby social support might lead directly to higher mental health outcomes because it also led to greater access to basic needs. However, as recommended by the classic Baron and Kenny (1986) model of mediation, significant correlations between Perceived Social Support from Family or Friends subscales or the Perceived Social Support Total scale with basic needs or the mental health variables would have been a prerequisite for mediation testing. Since these relationships did not exist in the data set (refer to Correlations Table 25), this mediation component of the hypothesis was not assessed.

5.3 Hypothesis 2 results

The second hypothesis related to differences in mental wellbeing according to which group the participants belonged; the host group or returnees. In addition, a moderation model was predicted whereby the strength of the relationships between basic needs, social support and acculturative stress on mental health may differ for the two groups.

First, some of the basic demographic differences between the host and returnee groups, previously outlined in the Method Section (see Chapter 4.1 Participants), was reviewed. The findings showed that more of the returnee participants reported separation
from their marital partners than the host group. As well, despite returnees tending to have better access to solid housing and town tap water, as well as higher levels of education, this did not translate to higher access to steady employment with 30% of returnees reporting regular employment compared with 42% of their host group counterparts. However, even though some group differences were observed amongst basic needs items, none of these group differences were statistically significant.

To establish if there were any significant differences between the host and returnee groups on the main variables, independent samples t-tests were performed. The Basic Needs Total Score was only used for this analysis because previous inspections of each of the basic needs items during the data screening process had already determined that there were no group differences between the host and returnee groups (see Chapter 4.3.3). The independent samples t-tests for the remaining variables revealed no significant differences in mean scores between the host and returnee groups on any of the subscales or total score measures. Table 26 summarises the outcomes of the independent samples t-tests by host and returnee group.

Table 26

*Descriptive Means and Independent Samples t-tests by Host and Returnee Group*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>Df</th>
<th>Sig. (2-tailed)</th>
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<tr>
<td>PSS: Family subscale</td>
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<tr>
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<tr>
<td>----------------------</td>
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<td>--------</td>
<td>--------</td>
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<td>--------</td>
</tr>
<tr>
<td><strong>AS: Somatic symptoms</strong></td>
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<td></td>
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<tr>
<td><strong>AS: Psychological symptoms</strong></td>
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<td><strong>HTQ: PTSD symptoms</strong></td>
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<td><strong>HTQ: Other impairment symptoms</strong></td>
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<td><strong>HSCL-25: Anxiety symptoms</strong></td>
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<td>Returnee group</td>
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<td><strong>HSCL-25: Depression symptoms</strong></td>
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<td>Returnee group</td>
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<td><strong>HSCL-25: Total score</strong></td>
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<td>16.40</td>
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</table>

**Note.** BN: Basic Needs; AS: Acculturative Stress; HTQ: Harvard Trauma Questionnaire; HSCL-25: Hopkins Symptom Checklist

Although the independent samples t-tests did not uncover any group differences amongst the variables of the study, the moderation model was tested to ascertain if the strengths of the relationships among basic needs, social support and acculturative stress on the measures of mental health were different for the host and returnee groups. Since the moderation model considered three independent variables (basic needs, perceived social
support and acculturative stress) plus two measures of mental health (HTQ and HSCL-25), the moderation analyses was performed six times. For the sake of parsimony, only total scores (as opposed to subscales) were assessed. The six moderation tests and their independent and dependent variables are summarised in Table 27.

Following the Baron and Kenny (1986) model of moderation and prior to running the moderation analyses, the independent and dependent variables were centred by computing a new variable less its mean value. An interaction variable was also generated to form part of the hierarchical regression procedures (i.e., group multiplied by each independent variable). To observe the change of the interaction variable of group status, the six moderation tests were computed using hierarchical multiple regression analysis in line with the Baron and Kenny (1986) method. That is, the independent variable and group were entered in the first step and the interaction term was entered in the second step for all six models. The results for each moderation test did not yield any significant group by independent variable interactions which indicated that the hypothesis regarding the strength of the relationships between basic needs, social support and acculturative stress on mental health was not supported across the two groups. A summary of the moderation analyses is provided in Table 28.
Table 27

Summary of Tests of Moderation based on Host/Returnee Status

<table>
<thead>
<tr>
<th>Moderation Test</th>
<th>Test Name</th>
<th>Independent variable</th>
<th>Dependent variable</th>
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<tbody>
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<td>Moderation test 1</td>
<td>BN- HTQ Model</td>
<td>Basic needs total score</td>
<td>HTQ total score</td>
</tr>
<tr>
<td>Moderation test 2</td>
<td>BN - HSCL-25 Model</td>
<td>Basic needs total score</td>
<td>HSCL-25 total score</td>
</tr>
<tr>
<td>Moderation test 3</td>
<td>PSS - HTQ Model</td>
<td>Perceived social support total score</td>
<td>HTQ total score</td>
</tr>
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<td>Moderation test 4</td>
<td>PSS - HSCL-25 Model</td>
<td>Perceived social support total score</td>
<td>HSCL-25 total score</td>
</tr>
<tr>
<td>Moderation test 5</td>
<td>AS - HTQ Model</td>
<td>Acculturative stress total score</td>
<td>HTQ total score</td>
</tr>
<tr>
<td>Moderation test 6</td>
<td>AS - HSCL-25 Model</td>
<td>Acculturative stress total score</td>
<td>HSCL-25 total score</td>
</tr>
</tbody>
</table>

Note. BN=Basic Needs; PSS = Perceived Social Support; AS=Acculturative Stress; HTQ=Harvard Trauma Questionnaire; HSCL-25=Hopkins Symptoms Checklist-25. For each moderation test, the moderator variable = host or returnee group status (coded 0=host; 1=returnee)
Table 28

Interaction Co-efficient Tests of Moderation by Host/Returnee Groups

<table>
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<tr>
<th>Dependent Variables</th>
<th>Unstandardised Coefficients</th>
<th>Standardised Coefficients</th>
</tr>
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<td>$\Delta R^2$</td>
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<td>.02</td>
</tr>
<tr>
<td>BN - HSCL-25 Model</td>
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<td>PSS - HTQ Model</td>
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<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td>AS - HTQ Model</td>
<td>.47</td>
<td>.06</td>
</tr>
<tr>
<td>AS - HSCL-25 Model</td>
<td>.72</td>
<td>.00</td>
</tr>
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</table>

Note. For each dependent variable, df(1,50). For each moderation test the interaction variable was group status (0=host, 1=returnee). BN=Basic Needs; PSS= Perceived Social Support; AS=Acculturative Stress; HTQ=Harvard Trauma Questionnaire; HSCL-25 = Hopkins Symptom Checklist-25
5.3.1 Additional exploration of the returnee group

Despite the lack of support for the second hypotheses regarding differences between the host and returnee groups, the returnee group data was examined more deeply, because of the aforementioned uniqueness of the sample/returnee group participants. Also, prior research revealed mixed results about whether a returnee group might show greater mental health than their host counterparts. On the one hand, they may show higher mental health than a host group because they had been distanced from the proximity of the conflict, but in contrast, a returnee group may have lower mental health given they had disrupted social supports and could be experiencing stress as they reintegrate to their homeland (Porter & Haslam, 2005). Thus, these analyses honed in on the migration experience of the returnee group to ascertain if the amount of time they spent away from their homeland or the amount of time in which they had been returned to their homeland was influencing their mental health outcomes.

A standard multiple regression analysis was used to assess the influences of the returnees’ migration experiences using the length of time they had spent out of South Sudan and in asylum ($M=17.40$ years, $SD=3.51$ years) and the length of time since they had been returned to their homeland ($M=22.09$ months, $SD=19.25$ months). Thus length of time away from South Sudan and length of time returned to the homeland were used as the independent measures. In two separate regression analyses, the HTQ total scores followed by the HSCL-25 total scores were utilised as the dependent variables. Given that the host group had not experienced time away from their homeland they were not relevant to the current analyses and were excluded from these analyses.

A preliminary evaluation of the independent variables observed one outlier in the returnee group, which was a male participant who had returned to his homeland for considerably longer than the rest of the sample (84 months). This participant was therefore
removed in the multiple regression analysis. Once this outlier was addressed there were no other violations of the regression assumptions.

In the first regression analysis that looked the HTQ total scores, the correlations table revealed a moderate, negative (i.e.: fewer trauma symptoms) and significant relationship between the length of time returnees had spent living outside of South Sudan and the HTQ total scores ($r=-.56, n=26, p<.01$). However, the length of time since they had returned to the homeland did not correlate significantly with HTQ total scores ($r=.28, n=26, p>.05$). The regression model indicated that 39.5% of the variance in the HTQ total scores could be explained by both the length of time displaced (time out of South Sudan) and the length of time the participants had returned to the homeland ($F(2,23)=7.51, p<.01$); however, the length of time spent away from South Sudan was the only statistically significant factor ($\beta=-.563, p<.01$) contributing to the variance in HTQ total scores. Therefore, the data point to a pattern indicating that the longer amount of time participants had spent in refuge and living away from their homeland, the better their mental wellbeing in the domains of trauma and other impairment symptoms, as measured on the HTQ.

In the next regression analysis, the variation in HSCL-25 total scores were considered in relation to the returnee participants’ length of time displaced and length of time returned to the homeland. Previously to the HTQ total scores, the correlation analysis revealed a moderate, negative and significant relationship between the length of time participants had spent away from South Sudan and the HSCL-25 scores ($r=-.41, n=26, p<.01$), but not with the length of time they had been returned to their homeland ($r=.21, n=26, p>.05$). The combination of time displaced and time returned to South Sudan contributed to 20.7% of the variance in HSCL-25 total scores, but this was not significant ($F(2,23)=3.00, p>.05$). However, the length of time that the participants had spent away from South Sudan did result in being significantly attributable to the variance in HSCL-25 total scores ($\beta=-.402, p<.01$).
Therefore, the more time returnee participants had spent away from their homeland was linked to fewer reported symptoms of anxiety and depression (as measured on the HSCL-25) and thus better mental health and wellbeing.

In summary, amongst the returnee group of participants in the present study, the length of time being displaced was significantly associated with better mental wellbeing, as measured by the HTQ and HSCL-25 total scores. Overall, the longer people had spent in displacement and away from their homeland, the lower their scores on the HTQ and HSCL-25, which was an indication of better mental wellbeing.

5.3.2 Post hoc analyses and potential problems with the acculturative stress measure

Significant differences had been expected between the host and returnee groups on the Catwe Acculturative Stress Scale (Berry, Kim, Minde & Mok, 1987), working from the theoretical basis that the returnees might experience higher stress as a consequence of their migration experiences than the host group. However, there were no group differences on the acculturative stress somatic symptoms subscale ($t(51)=-.91, p>.05$), the acculturative stress psychological symptoms subscale ($t(51)=-1.18, p>.05$) or the acculturative stress total scores ($t(51)=-1.17, p>.05$). Furthermore, the Pearson correlations of the acculturative stress subscales and total scores were positively and strongly correlated with all of the subscales and total scores of the HTQ and HSCL-25 measures. A summary of the correlations between the acculturative stress subscales and total scores and the HTQ and HSCL-25 subscales and total scores is presented in Table 29.
Table 29

**Pearson’s Correlations Between the Acculturative Stress Subscales and Total Scores and the HTQ and HSCL-25 Subscales and Total Scores**

<table>
<thead>
<tr>
<th></th>
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<th>2</th>
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<th>4</th>
<th>5</th>
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</thead>
<tbody>
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<td></td>
<td>r</td>
<td>r</td>
<td>R</td>
<td>r</td>
<td>R</td>
<td>r</td>
<td>r</td>
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<td>r</td>
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<td>.48**</td>
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<td>.58**</td>
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<tr>
<td>2. AS: Psychological symptoms subscale</td>
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<td>.72**</td>
<td>.70**</td>
<td>.63**</td>
<td>.68**</td>
<td></td>
</tr>
<tr>
<td>3. AS: Total score</td>
<td>-</td>
<td>.59**</td>
<td>.69**</td>
<td>.67**</td>
<td>.74**</td>
<td>.65**</td>
<td>.74**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. HTQ: PTSD symptoms subscale</td>
<td>-</td>
<td>.84**</td>
<td>.94**</td>
<td>.79**</td>
<td>.81**</td>
<td>.83**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. HTQ: Other impairment symptoms subscale</td>
<td>-</td>
<td>.97**</td>
<td>.87**</td>
<td>.89**</td>
<td>.91**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. HTQ: Total score</td>
<td>-</td>
<td>.87**</td>
<td>.89**</td>
<td>.91**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. HSCL-25: Anxiety symptoms subscale</td>
<td>-</td>
<td>.87**</td>
<td>.95**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. HSCL-25: Depression symptoms subscale</td>
<td>-</td>
<td>.98**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. HSCL-25: Total score</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>


**p<.01
The most notable correlation for the Acculturative Stress Total Scores was with the HSCL-25 Anxiety Symptoms Subscale \((r=0.74, p<0.01)\) and subsequently, the HSCL-25 total score \((r=0.74, p<0.01)\). The positive direction of the associations indicates that high acculturative stress total scores were strongly linked to high HSCL anxiety and total scores, which further suggests that the acculturative stress measure and the HSCL-25 anxiety subscale may be measuring similar constructs. A calculation of the coefficient of determination between the Acculturative Stress Total Score and the HTQ Total Score revealed a shared variance of 44.9% while the Acculturative Stress Total Scores and HSCL-25 Total Scores shared 54.7% of the variance. These findings additionally suggest that the acculturative stress scale used in the present study appeared to be measuring similar features of trauma and other impairment symptoms, anxiety and depression, which were already being measured by the HTQ and HSCL-25. Thus, the utilisation of the acculturative stress measure in the present study may not have achieved sufficient discriminant validity when implemented alongside the other wellbeing measures.

Due to the small sample size, a full factorial analysis of the acculturative stress and HTQ and HSCL-25 subscales to check their factorial validity was not feasible. However, the correlation coefficients of determination sufficiently denoted that the two scales may not be differentiating between the overall measures of wellbeing (e.g., trauma and other impairment symptoms on the HTQ and depression and anxiety symptoms on the HSCL-25) and acculturative stress. Instead, it may be tapping into similar physical and psychological symptoms. In doing so, the acculturative stress scale used in the present study, particularly in the context of the Southern Sudanese sample group, may need to be viewed more as a measure of overall wellbeing (as are the HTQ and HSCL-25) than a true representation of acculturative stress. Naturally, with this observation regarding the potential weaknesses of
the acculturative stress measure in the present research design, the results and findings in relation to acculturative stress need to be interpreted cautiously.

5.4 Study 1 summary of findings

The quantitative results in study one revealed important learnings about the mental health and wellbeing of this study’s sample group with some hypotheses supported and others unsupported. As part of the exploratory analysis it was determined that women had significantly less educational attainment than men as well as significantly higher scores, and thus lower mental wellbeing, on the acculturative stress, Harvard Trauma Questionnaire (HTQ) and Hopkins Symptom Checklist-25 (HSCL-25) measures. Higher education was also associated with higher levels of steady employment and wellbeing, but the links between gender, education and employment did not result in a flow-on effect for women; rather, being female was a sole predictor of poorer mental health and wellbeing.

Higher education was also related to having greater access to health care, employment and overall wellbeing. Employment was linked to greater access to basic needs as well as mental health. Age, or being older, was additionally associated with lower scores on the acculturative stress, HTQ and HSCL-25 measures, thus, age predicted increased wellbeing.

In the analysis of the first hypothesis, it was confirmed that higher scores on having access to basic needs was significantly associated with lower scores on the acculturative stress, HTQ and HSCL-25 measures. However, social support from family or friends did not predict or show any significant associations with increased mental wellbeing. Higher acculturative stress scores were significantly linked to higher HTQ and HSCL-25 scores, however the additional analyses of the acculturative stress scale suggested that this may have been due to the acculturative stress measure being unable to specifically separate the
experiences of acculturative stress and other wellbeing constructs, such as anxiety symptoms measured on the HSCL-25.

The analyses related to the second hypothesis revealed no significant differences between the host and returnee groups on their access to basic needs, perceived social support, acculturative stress or other wellbeing measures. However, it was determined that for the returnee group, the longer amount of time people had spent away from their homeland of South Sudan the better their mental health and wellbeing, as shown by few symptoms on the HTQ and HSCL-25. This finding may reflect some of the reprieves returnees experienced from the intensity of the South Sudan conflict, which also supports Porter and Haslam’s (2005) proposal that poorer mental health is likely for those with closer, longer and more intensive proximity to conflict hostilities.

The first and second hypotheses of the current research were only partially supported by the data. The idea of mediating and moderating variables could not be assessed, particularly in light of the perceived social support and acculturative stress measures failing to statistically correlate or influence the wellbeing dependent variables. Despite this, the quantitative results in the present study revealed some interesting findings that have begun to shed light on what the influences of basic needs, social support and migration might be on the wellbeing of people living in South Sudan. From this point forward, the qualitative data was analysed to further enlighten the statistical findings and continue the study’s investigations, specifically exploring the participants’ subjective impressions about mental illness and how this links with their poverty context.
CHAPTER 6: SECOND STUDY RESULTS - IMPRESSIONS OF MENTAL ILLNESS IN SOUTH SUDAN

The second study aimed to expand on how people in South Sudan viewed mental health as one of the many needs in their context. Focus was on how the unique Southern Sudanese culture prescribed the presentations, causes and treatments for mental illness and whether this related to their recent experiences of war. The study further aimed to ascertain if participants viewed their futures positively or negatively, despite living in poverty and hardship. Possible differences in views between the host and returnee were also considered given their differing wartime and migration experiences.

The quantitative results offered a deductive approach to the research questions; specifically, whether participants’ access to basic needs, social support and migration experiences were influential to their overall mental health and wellbeing. However, the inductive and qualitative approach in this second study permitted a more in-depth analysis of the cultural nuances of the South Sudan context and the participants’ perceptions of mental health and wellbeing.

A semi-structured interview format was employed to enable respondents to openly express their views about their community needs and their culturally derived beliefs about mental health and wellbeing. This supports the ideals put forward by mental health professionals working in mental health care in humanitarian situations, where there is concern about the limited usefulness and poor cultural adaptation in purely taxonomic approaches to research in developing countries such as in Africa (Kleinman & Cohen, 1997; Thakker & Ward, 1998; van Ommeren, Saxena & Saraceno, 2005; Weiss, Saraceno, Saxena & van Ommeren, 2003). Although qualitative data about mental illness in developing contexts is expanding, there are very few published accounts about mental illness specific to
South Sudan. This further justified the importance of building the understanding about mental health issues in this region of Africa.

6.1 Research questions

To allow emergent data to materialise from the participants’ responses, formal hypotheses were not stipulated. Instead, five broad research questions were developed to investigate themes relevant to how basic needs and social support might be linked with mental health and wellbeing in South Sudan, what the locally prescribed and culturally determined ideas were with regard to mental illness, and whether or not differences in perceptions about these issues between the host and returnee groups were evident. Specifically, the research questions of the second study were:

1. What are the social structures of the community?
2. In the participants’ eyes, is the current state of poverty in South Sudan a greater need than mental health concerns or the traumatic experiences from the war; and how do people in South Sudan associate their access to basic needs and social support with mental health?
3. What do people in South Sudan perceive as the causes, symptoms and treatment options for mental illness; and how do their communities respond to those with mental illness?
4. Do participants view themselves as having some autonomic control in their lives; and
5. How do participants view their short term and long term futures and is this influenced by their current situation?

The following sections describe the participants, outline the specific interview questions used in the second study and the qualitative data treatment approaches, which were based on Braun and Clark’s (2006) Thematic Analysis approach and Smith and Osborne’s (2008) Interpretive Phenomenological Approach – both well-established qualitative data
analysis methodologies. These sections are followed by a disclosure statement of the researcher (as recommended by Stiles, 1993) and a systematic presentation of the findings.

6.2 Method

6.2.1 Participants

Participants in the second study were the same as those in the first study; the host group of 26 Sudanese nationals who had never left south Sudan during the civil war (13 men & 13 women) and the returnee group of 27 Sudanese nationals (14 men & 13 women) who had left South Sudan’s borders during war time and had been displaced for a minimum of 11 years to a maximum of 25 years (M= 17.40, SD=3.51 years). The number of months the returnee group had been residing back in their homeland ranged from ranged from 1 month to 84 months, with an average of having been returned for less than two years (M=22.09, SD=19.25 months). All participants were adult, with ages ranging from 20 to 50 years (M=33.67, SD=8.01 years).

An additional participant in the second study was the translator, who participated in a three-hour key informant interview. This key informant interview helped clarify some of the local terms and customs mentioned by the participants, and provided supplementary information about Southern Sudanese cultural practices. Full details of the participants and additional demographic data are in Chapter 4.

6.2.2 Semi-structured interview questions

Open questions used in this second study provided interviewees with the freedom to speak of all concerns facing them and their communities, including but not limited to mental health concerns. The qualitative data generated from the analysis of the responses enabled exploration of the likely links between mental health and wellbeing and poverty, or lack of basic needs (WHO, 2001). Participants were able to use their own language and terms to express their beliefs about the causes of mental illnesses and to consider their individual and
communal responses to those within their communities with mental health problems. Additional questions invited participants to consider their feelings of control about their current situation and their outlook about the future, which allowed the research to delve into local insights about how poverty, war and uncertainty influenced (or did not influence) their conceptions of their future wellbeing. The full interview schedule is presented in Appendix B.

To answer the five research questions, the semi-structured interview posed a range of questions to participants, which formed the basis of the qualitative data analysis. Table 30 provides a summary of the research questions and the enquiries used in the semi-structured interview that related to them. The theoretical basis of the questions used in the semi-structured interview follows.

Table 30

**Qualitative research questions and their Association with Questions asked in the Semi-Structured Interviews**

<table>
<thead>
<tr>
<th>Research question</th>
<th>Questions used in the semi-structured interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the social structures of the community?</td>
<td>• To which tribe do you view yourself as belonging to?</td>
</tr>
<tr>
<td></td>
<td>• Are there any other tribes or social groups you spend time with?</td>
</tr>
<tr>
<td></td>
<td>• Who sets the rules and laws that your family follow in your community?</td>
</tr>
<tr>
<td>2. In the participants’ eyes, is</td>
<td>• What do you see as the main problems that</td>
</tr>
</tbody>
</table>


The current state of poverty in South Sudan a greater need than mental health concerns or the traumatic experiences from the war; and how do people in South Sudan associate their access to basic needs and social support with mental health?

3. What do people in South Sudan perceive as the causes, symptoms and treatment options for mental illness; and how do their communities respond to those with mental illness?

- What would be the signs that someone in this community might be having emotional or mental health problems?**
- Do you have any special names for emotional or mental health problems?**
- In your opinion, what causes emotional or mental health problems?*
- How would you go about finding treatment for someone with an emotional or mental health problem?*
- How does your community react if somebody has serious emotional or mental health problems?*
4. **Do participants view themselves as having some autonomic control in their lives?**

- Do you feel like you have control over what happens in your life?

5. **How do participants view their short term and long term futures and is this influenced by their current situation?**

- When you think about your future, how do you imagine your life will be in two years’ time?
- How do you imagine your life will be in 10 years’ time?

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Research questions one and three, largely pertaining to social order and local perceptions of mental illness, utilised questions directly from the DSM-IV-TR (2000) Cultural Formulation. Research question two focused purely on local perceptions of community concerns and sentiment, with interview questions drawn from Bolton, Neugebauer and Ndogoni (2002) study. Following this, two questions from the Bolton et al. study were posed about what might be locally prescribed signs of mental disorder. Bolton et al. used responses to these questions to generate an adapted and context specific Hopkins Symptoms Checklist; however, this was not the goal of the open-ended questions in the current study. Instead, the intent was to obtain a detailed understanding of local perceptions of the ubiquitous issues facing communities and how this might relate to mental health and wellbeing.
To increase understanding of the causes and presentations of mental illness specific to the culture and context of South Sudan – research question three – interview questions were developed following the Cultural Formulation of the DSM-IV-TR (APA, 2000). Although the DSM-IV-TR Cultural Formulation relates specifically to individualised diagnosis, the present research used these individual questions more broadly in relation to communal perceptions and ideas about mental illness. For example, instead of seeking explanations of an individual’s specific illness (a diagnostic goal), questions focused on how the individual and their community perceived the causes of emotional or mental health problems and any specific names they may have for those illnesses. Also, questions from the Cultural Formulation that related to individual treatment and care were not used in the present research. Table 31 shows the interview questions developed for the qualitative study, based on the DSM-IV-TR (2000) Cultural Formulation categories.

The final section of the interview focused on research questions four and five, which sought to determine participants’ feelings of control about their present situation and their views about the future. To determine if participants had a sense of autonomy and/or helplessness about their poverty and life-situation, they were simply asked: “Do you feel like you have control over what happens in your life?” If participants responded in a yes/no/don’t know manner, probe questions were used to elicit additional information, for example: “Can you give me an example of some of those things that are impossible to solve?” or “can you explain to me which problems you can solve and which you cannot?”
Table 31

*Interview questions developed for the qualitative research, based on the DSM-IV-TR (APA, 2000) Cultural Formulation categories*

<table>
<thead>
<tr>
<th>DSM-IV-TR (APA, 2000) Cultural Formulation categories</th>
<th>Related qualitative questions developed for research</th>
</tr>
</thead>
</table>
| Cultural identity of the individual                   | To which tribe do you view yourself as belonging to?  
|                                                      | Are there any other tribes or social groups you spend time with? |
| Cultural explanations of the individual’s illness      | In your opinion, what causes emotional or mental health problems amongst people in your community? |
| Cultural factors related to psychosocial environment and levels of functioning | Who sets the rules and laws to which you and your family follow?  
|                                                      | How would you go about finding treatment for someone with emotional or mental health problems?  
|                                                      | How would your community react if someone had serious emotional or mental health problems? |
| Cultural elements of the relationship between the individual and the clinician | Not applicable |
| Overall cultural assessment for diagnosis and care     | Not applicable |
Interview questions related to the participants’ impressions of the future (research question five) were adapted from Marshall and Arvay’s (1999) study on adolescents’ sense of self. Marshall and Arvay’s well-framed questions identified considerable differences between boys and girls and provided a guide for posing a similar future orientation question to the current sample group. However, rather than asking the question “When you think about your future, how do you imagine your life will be?”, the approach was slightly modified to obtain views of the future both in the short term (2-years) and the longer term (10-years). This also provided a basis for ascertaining whether the Sudanese sample group felt they had a foreshortened future, or the potential for personal growth and ongoing development regardless of their poverty status.

6.3 Qualitative data treatment

The interviews, including consent from all participants and a key informant interview were transcribed using English translations of questions and answers. English translation took place in ‘real time’ during the participant interviews. Therefore, transcripts of qualitative interviews were transcribed based solely on those English translations. This was a basic approach to data collection because thorough back translations were neither feasible in ‘real-time’ nor affordable for the research project.

Working from the English translations and transcripts, thematic analyses, as recommended by Braun and Clarke (2006), was employed to analyse responses. Based on Braun and Clarke’s six-phases of thematic analysis, the data were analysed systematically, involving the process of (1) familiarisation with the responses to each question; (2) generating initial thematic codes using simple theme summaries; (3) searching for emergent themes amongst those codes; and (4) reviewing the themes. To ensure greater objectivity of the themes, responses to each question were reviewed through an independent audit process (refer to Appendix H), which confirmed the relevance of the material to the thematic themes.
they allotted; (5) The themes were then defined and each theme given an overarching name; and (6) identifying exemplary, representative and descriptive extracts from the data to present for the results.

Throughout the thematic analysis, some interpretive meaning of responses was applied, using an Interpretive Phenomenological Approach (IPA) recommended by Smith and Osborne (2008). IPA aims to unravel perceptions or accounts according to their underlying meaning, or sentiment, as opposed to concentrating on the literal terms or information provided. Interpretative phenomenological approaches commit to reviewing information from participants on the basis that they encompass verbal, cognitive and emotional states, and analysis for themes to be ascertained from the data is required to account for an overall interpretation. Thus, the analyses scrutinised responses and collated themes according to their common interpretative meanings and enabled the data to be presented with connotation that was idiographic of the unique Southern Sudanese sample group. Following the thematic analysis and IPA data treatments, the allocation of responses to specific themes were independently audited. This further strengthened reliability of the data and their interpretations into the emergent themes. A letter of attestation, which also outlines procedures for the independent audit can be found in Appendix H.

Added to the thematic analysis and IPA, notes were summarised regarding the presentations of the participants and their body language. Lastly, clarifications regarding some of the information received from participants were obtained during a key informant interview with the translator.

Although some researchers have argued that the merging of qualitative methodologies for analysis can potentially dilute results (e.g., Glasser, 1992), Leech and Onwuebguzie (2008) suggested that using elements of multiple approaches to qualitative analysis is a valid approach, because utilising various qualitative techniques contributes towards strong and
accurate representation of the participants views about the issue being researched. In this instance, an adapted and combined approach to qualitative analysis, primarily using thematic analysis (Braun & Clarke, 2006) and IPA (Smith & Osborn, 2008), was expected to draw a concise and clear understanding, from the Southern Sudanese cultural perspectives, on the causes, presentations and treatments of possible mental or emotional disorder and how the current living conditions in South Sudan have influenced individuals’ lives, experiences and views of the future.

6.4 Researcher disclosure: Personal reflections on mental health in humanitarian contexts

One of the challenges long identified in qualitative research methodology is the inherent potential of personal bias in the analysis and interpretation of data (Glasser, 1992; Stiles, 1993). Stiles discussed the importance of the researcher’s disclosure regarding their personal investment surrounding the research initiative, and the need to document the process by which the researcher arrived at their interest in their area of study. In the spirit of disclosure, this chapter provides some background to the author of this study and the historical progression of thinking that led to interest in the broad area of mental health in humanitarian contexts.

I have worked in the humanitarian aid sector for approximately 12 years. My early work in this field was from a Communications perspective, later followed by a ‘generalist programming’ position, which saw me manage a range of projects in post-crisis countries, such as water and sanitation in Ethiopia, disaster preparedness in Latin America and a variety of programs (e.g., food aid, education, food for work, health, nutrition) in Africa, including South Sudan. Work also included ‘emergency deployment’ to a number of humanitarian crises, including (but not limited to) the 2004 Sri Lanka Tsunami response, 2005 Horn of Africa Drought response, 2008 Darfur crisis, 2009 Israeli-Gaza conflict and the 2010 Haiti
Earthquake response. Throughout this time, I also spent a cumulative total of approximately
12 months living and working in South Sudan following implementation of the 2005
Comprehensive Peace Agreement.

My first mental health research initiative in the humanitarian aid sector involved
qualitative study in Rwanda, 2004, ten years after the genocide. As a psychology student, I
was particularly interested in the experiences of youth who had survived the genocide and
how their traumatic experiences from the war impacted their daily lives. Similar to some of
the research emerging at the time, which suggested that Posttraumatic Stress Disorder
(PTSD) was endemic in conflict-affected countries (e.g., de Jong et al., 2000), I had
hypothesised that the majority of the participants (all of whom had one or both parents killed
in the genocide and witnessed various horrific events) would present with post-trauma
symptoms and would be in need of targeted mental health support. However, outcomes of
this study revealed that the youth were in much greater need and concerned about their
ongoing material supports, such as education fees, vocational opportunities and access to
adequate food, water and shelter. This led me to go beyond psychological theory and
literature and examine some of the themes developing in the global mental health space, from
humanitarian perspectives. For example, debate regarding the usefulness of so-called
‘western’ taxonomic diagnoses when mental health care is inaccessible, how to establish
research measurement in non-Anglo cultures, the differences between the clinical
perspectives of mental health and the broader notions of psychosocial support programs,
which were becoming part of the humanitarian vernacular.

As I continued working in the humanitarian sector and became more involved as a
mental health technical advisor for humanitarian programs, the World Health Organization’s
(2001) documented links between poverty and mental illness were confirmed for me time and
again. As I visited numerous developing countries and responded with programs in
humanitarian crises, I observed that the less people had access to their basic and survival needs the more stress, sadness, hopelessness and dependence they expressed. This was no more real than in South Sudan, where development had been at a standstill for more than 20 years of their civil conflict. Nonetheless, as I spoke with people from within the psychology and humanitarian sectors about South Sudan, there remained a belief that the majority of people must be ‘traumatised’ from the war and needed mental health care, neglecting to acknowledge the lowest global education and nutrition rates for children and living conditions that were beyond basic and some of the most primitive I have ever seen.

Since this time, the global mental health movement has achieved great strides in better defining mental health and psychosocial support. A turning point has been the development of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007), which has offered humanitarian responders a useful and logical framework for working in this mental health and psychosocial support space. However, much work remains to be done. The IASC Guidelines are an evidence-informed approach, as opposed to evidence-based and they require ongoing research to confirm their legitimacy. Many good-willed psychologists from northern practices continue believing in provision of clinical care models in humanitarian crises and persistently neglect integration of programs that will help restore the basic survival needs of the affected populations, in addition to undermining how communities find ways of caring for each other, within their established social and cultural support systems. Added to all of this, many humanitarian organisations persist in responding to population groups with assumptions that all people require the same types of support, often failing to account for gender, age, migration status or levels of community and social support. I observed this personally in South Sudan where many recent returnees complained of being unable to access employment due to their host counterparts being more socially connected.
Since 2008, I have furthered my psychology education (and humanitarian aid experience) and have been working full time in a mental health and psychosocial support technical capacity. My current role under the employ of a large international relief and development agency involves assessing the mental health and psychosocial needs amongst communities affected by crises, designing mental health and psychosocial support programs and providing ongoing technical assistance to their implementation. A lot of time is spent providing capacity building initiatives to local staff who manage the day-to-day operations of these programs. My role also includes a lot of engagement with partners and colleagues from a multitude of other humanitarian aid agencies, supporting the development of international guidelines to some elements of mental health care (e.g., Psychological First Aid; World Health Organization, War Trauma Foundation & World Vision International, 2011). I disclose that I am also a member of the Inter-Agency Standing Committee Mental Health and Psychosocial Support Reference Group, which advocates globally for the utilisation of the IASC Guidelines in all humanitarian crises.

It is with this history of my involvement in mental health and psychosocial support programming that I embarked upon the current study; in an attempt to test my hypotheses that developing contexts are, first and foremost, experiencing greater stress from their poverty status than their traumatic experiences of war. This is not to say that I do not believe people in developing countries do not experience mental illness – indeed I have witnessed many presentations of such, including depression, anxiety, PTSD, psychosis and a range of developmental disorders (to name but a few), where clinical intervention is desperately needed. I feel we must always consider mental health care in light of how individuals perceive mental illness within their social and cultural constructs, and to find ways to ensure that psychosocial care, more broadly, can be better integrated into the range of programs humanitarians already offer, such as livelihoods programs, community care coalitions, health
care and so on. I believe, if we can continue providing programs to support basic survival needs, as well as helping communities to reconnect to their social support systems, we can lessen the demands for the clinical and specialised care and interventions. Through this research project, I wish to clarify if my perspectives on these matters are accurate, evidence-based and supportive of current humanitarian thinking; and how this may or may not concur with notions of mental health and wellbeing in more developed contexts. Therefore, the hypotheses and research questions of the current research have evolved from psychological literature, humanitarian literature, humanitarian practice and my personal observations and knowledge of the humanitarian mental health and psychosocial support sector within the global mental health space. Further, I acknowledges that there may be potential bias in the interpretation of the qualitative data based on personal beliefs and observations that poverty is likely to play a greater role in the mental health and wellbeing of Southern Sudanese people (whether they remained in-country during wartime or were recent returnees), than their traumatic stories or experiences of war.

Finally, material from this research project is to be used to inform our organisational programs in South Sudan. Data will contribute towards establishing culturally appropriate ways to provide mental health and psychosocial support considerations into existing programs, or to develop new programs that may also serve to support the mental health and wellbeing of communities there.

6.5 Results from the analyses of the subjective impressions of mental illness in South Sudan

This section is structured to methodically follow the five research questions and bring together the common themes derived from responses to the related interview questions (refer to Table 31). For ease of reference, each section first provides a summary table of the key
themes that emerged to each research question, and explanations and descriptions of those themes follows.

6.5.1 Social structure for participants in their community

The first research question aimed to ascertain local and customary social structures in the participants’ communities. Qualitative analysis identified four emergent themes list in Table 32.

Table 32

Research question 1: Summary of emergent themes and their relationship with the qualitative research questions

<table>
<thead>
<tr>
<th>Research question</th>
<th>Emergent themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the social structures of the community?</td>
<td>• Shilluk tribe ( (n=52) ), Lafon tribe ( (n=1) )</td>
</tr>
<tr>
<td></td>
<td>• Social engagement was shared across the tribes ( (n=52) )</td>
</tr>
<tr>
<td></td>
<td>• Family rules were set by family elders ( (n=53) )</td>
</tr>
<tr>
<td></td>
<td>• Community rules were set by the Shilluk King ( (n=24) ), Community leaders ( (n=19) ) or the Government ( (n=4) )</td>
</tr>
</tbody>
</table>

As shown in Table 32, all but one participant identified themselves as belonging to the Shilluk tribe. The exception was a male returnee who initially belonged to a small tribe in the more southern regions, called the Lafon tribe; but he explained that following the development of friendships with others in the Shilluk tribe while he was in exile, believing these friendships were as strong as family relationships, and recognition of a future united South Sudan, he was satisfied to have changed regions upon returning to his homeland. The
following is an excerpt from this participant’s experience of moving to live with different tribe:

[Male, Returnee, age 31] Yeah, *I belong to a very small tribe in the south called Lafon. It is about 60 mile from a town of Torit, in Equatorial, that is Juba. But what post meaning to live in Malakal now, since I left my homeland, that time, and I miss all my lovely brothers and when I go to exile I got some friends from this region, so they become like my relatives, and now I don’t mind going back to where I was born in, so I become a person of this region, since its Sudan.*

The majority of participants indicated that their social engagement was not limited to their own Shilluk tribe. Participants reported spending time with the Dinka (n=28), Nuer (n=32), Arab (n=8) and Nuber (n=6) tribes, as well as with people from the Equatorial Juba regions (n=6) who had moved into the Shilluk areas. Some participants spent time with the much smaller tribes of the region, each of which received less than three mentions: the Kor, Fur, Moab, Kakuyu, Anuak, Mabung, Morle and Fungny tribes. Interestingly, of the returnee group, only one participant indicated not spending time with tribes outside of the Shilluk tribe, while the host group had five individuals who said “no” to spending time with other tribes. Another difference was that the host group were more inclined to mention spending time with the smaller tribes, such as the Morle and Mabung, while the returnee group tended to mention the more prominent tribes, such as the Dinka, Nuer and Arabs. This suggests that while the host community showed greater familiarity with the tribal diversity of the region, they were possibly less integrated with other tribes and more tribally affiliated with their own Shilluk kinfolk. Nonetheless, the majority indicated that spending time with a variety of tribal people was normal for their context:

[Female, Returnee, age 38] *Yes there is. There is the Nuer and there is the Dinka. People are living mixed. And there is Arabs also.*
When exploring the psychosocial environment the participants were living in, they were asked about who set the rules for them to follow in their social context. Participants revealed two distinct themes where rules were set differently for families and communities. Rules for the family were set first and foremost by the family elders, followed by the man of the household, or where there was not a male head of household, by the female heads of household. The following participants described this process:

[Male, Host, age 23, Theme: Rules set by family elders] *He is saying there is no specific rule but he just follow the system that the eldest people have before.*

[Female, Host, age unknown, Theme: Rules set by family elders] *So since there is no husband she is the one to set the rules for the family.*

The second theme about rules that governed families and their society revealed mixed views about who set the rules for their community. Only four respondents mentioned the government as having a role in setting rules for the community, three mentioned the role of religion (in family and/or community rule-setting) and only four people mentioned “tribal laws”. However, the majority still implied a tribal approach to local governance by attributing the Shilluk King and/or the community-based leaders and elders, sometimes also referred to as chiefs, who set the rules for the community.

[Host, Male, age 25, Theme: Community rules set by the Shilluk King] *The Shilluk because there is a king who provide the rules for the community and the family. The King of Shilluk.*

[Host, Female, age 30, Theme: Community rules set by Community Leaders] *Yes there is a chiefs, he is called the chief of the block, because they consider it one block so he is the one who rules and is the leader of that one block. So he is responsible for anybody who is living in that one block.*
[Returnee, Female, age 40, Theme: Community rules set by the Shilluk King; Community rules set by Community Leaders] There are two types. There is the rules made by chiefs, and there is another one, done by the King of Shilluk.

6.5.2 Participant perceptions and feelings about community problems

The second research question began the process of delving into local and cultural perceptions of how the participants viewed their present situation and what they believed to be their greatest community concerns. The emergent themes are summarised in Table 33.

Table 33

Research question 2: Summary of emergent themes about community problems, feelings about the present situation and names for people with emotional or mental health problems

<table>
<thead>
<tr>
<th>Research question</th>
<th>Emergent themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. In the participants’ eyes, is the current state of poverty in South Sudan a greater need than mental health concerns or the traumatic experiences from the war; and how do people in South Sudan associate their access to basic needs and social support with mental health?</td>
<td>• Main problems in the community were perceived to be Lack of basic needs (n=29), Insecurity (n=24), Alcohol abuse (n=9) and Cultural shifts (n=7; returnee group only). • In relation to how people felt about their present situation, participants expressed sentiments of Despair (n=35), Optimism (n=11) and a need for Government leadership (n=9)</td>
</tr>
</tbody>
</table>
6.5.2a Main problems in the community

Responses to the question (taken from Bolton, Neugebauer & Ndogoni (2002)) “What do you see as the main problems that affect people in this community?” reflected that the participants’ lack of basic needs was the main problem in their community, as well as insecurity and alcohol abuse. Interestingly, a fourth theme was only evident in the returnee group, who viewed cultural shifts in their community as a key problem. This suggests that the returnee’s perceived cultural norms differently to their host counterparts, which were potentially salient for them as they adapted to living back in their homeland after years of asylum.

A description of the four discrete themes about areas of concern for the participants is provided, followed by examples of these themes, where interviewees often reflected multiple themes in their responses.

1. **Lack of basic needs** – participants reported immediate and survival needs as being the main problems they viewed as affecting people in their community. Lack of basic needs included lack of water, employment opportunities, food, money and challenges regarding land rights, housing and education.

2. **Insecurity** – the second prominent area of concern was insecurity, such as worry about the peace process, tribal conflict, proliferation of arms, local banditry (in town and the bush), uncertainty about peace and worry about future instability.

3. **Alcohol abuse** – Participants also described problems with increased alcohol consumption in the community, particularly for those without jobs, individuals wishing to escape reality, and youth who were out of school.

4. **Cultural shifts** – Only those in the returnee group reflected a range of concerns about changes to their familiar and expected Southern Sudanese way of life. They were concerned with the increased Arabic influence in the township of Malakal, lack of care
for returnees, greater focus on independent lifestyles, urbanisation and continued migration. Two people described this:

[Male, Returnee, age 31, Themes: Lack of basic needs, Insecurity] Yeah, when I reach Malakal especially, both returnees and even the indigenous, in fact, I found so many problems facing them... In fact it’s not the kind of place a person can live in, in fact... even food, even their basic needs, some of them cannot afford doing that in the way people like me can try even at least to do that... The situation is very, very serious.... and these people in fact they are really suffering. They are just depending on hardship, you know that they are working very very hard. They are collecting some firewood, some are just spending the time just in the bush, which is very very danger, dangerous.

[Male, Host, age 26, Themes: Lack of basic needs, Alcohol abuse] It is the problem of work so someone like him he completed secondary school, so when he look for a job it is very difficult to get the job. So most of the people have not work. He is saying that people are drunk. If they feel there is no job then they go looking for a group like them, those who are jobless, they collect themselves and of course where to drink. So they turn to drink.

[Female, Host, age 20, Theme: Insecurity] She is saying there are many problems. She is giving the example of the fighting with the tribe last time. This is a problem also. She is saying there are many, she cannot count them.

[Male, Returnee, age 31, Theme: Alcohol abuse] ...there is a lot of changes in their life. Maybe they change their attitudes to drinking, just to relieve them from, you know alcohol sometime, it deceive people that it gives some sort of joy, but this is really confusion.
[Male, Returnee, age 67, Themes: Cultural shifts, Insecurity] He’s talking about the Islamic or the Arab culture that is affecting the community. If you are not a Muslim then maybe they will attacks you or they kill you sometimes or they just chase you from one place to another place. Sometimes they caught to the ladies at the market somewhere they got them. If they looking at me like that their person, they put you in the prison in the night... and they told you if you want to work in the area change your colour is to be like us.

[Male, Returnee, age 39, Themes: Cultural shifts, Lack of basic needs] So he is saying that there are bad things interfering to the community now, so the system is not as it was before. So before the community, they take care for themselves [their tribes] and protect themselves. But now, there is nobody take care of each other so everybody is independent. So each one is running to look for his interest and he is looking for food or work so he can run to any or other community, living in any community.

6.5.2b Feelings about present situation

To further explore possible links between participants’ poverty and post-war context and their mental health and wellbeing, another open-ended question (taken from Bolton, Neugebauer & Ndogoni, 2002) asked participants how they felt about their present situation; specifically “How do you think people in this community feel about their present situation?”. Responses varied and reflected a range of emotions from feeling negative about their present situation, feeling hopeless, fearful about the future, saddened about the continued tribal insecurity, reporting on the difficulty of their poverty and life situations and general unhappiness. These interpretations were grouped together as a sense of “despair” about their present situation. In contrast, but to a lesser extent, some interviewees reported a sense of optimism about the future and felt that since the war was dying out they sensed that things were better than the past or different. These sentiments were grouped together to reflect
participants’ sense of “optimism”. Finally, and distinct from other feelings described by the participants, there was also a sense of desire or need for “government leadership” to support the people in their present situation. Thus, the thematic analysis indicated that participants viewed their present situation within three main themes: Despair, Optimism and Needing Government Leadership. These themes are described below, followed by excerpts from the interview responses that illustrate those themes.

1. **Despair** – This theme represented participants’ feelings and reflections of hopelessness, fear, sadness, poverty-bound and general unhappiness, illustrated in the following statements:

   [Female, Host, age 39, Theme: Despair] *So people are confused because this situation, they are hopeless, this situation might not change. They [the problems] become a part of life of people. They are hopeless, they think these things might not change in their life.*

   [Female, Returnee, age 38, Theme: Despair] *So she is saying there is no good feeling of the people because when they came from the north they were hoping that they would be better in their own land, but when they arrive so they find the situation is very bad and then people are hopeless. So they have been gone for years but they are in the same situation and there is no difference between the north and the south.*

2. **Optimism** – To a lesser extent, but with a number of participants reflecting change in their community, the theme of optimism was indicative of feelings that described participants’ confidence about their situations improving, particularly in light of the hope for South Sudan’s independence and the cessation of conflict. This is shown in the following statements:

   [Male, Host, age 23, Theme: Optimism] *He’s saying that the community somehow is more better than before. So he’s saying that the better he mean here because*
previously people are afraid to come to the town other than to leave their villages.

But now, **people are free, you can come, you can go, you can live in the village better than before.** In the past people are living in the forests.

[Male, Returnee, age 50, Theme: Optimism] *So now he’s saying that it is more, some more better than before because in the time of war people suffer a lot more than the present. Because now the roads are open, so road to the north to Juba and to, even to Ethiopia so many things are entering. There is people can struggle a bit, so they run here and there and to get the daily needs. He mention the water, this water is not available before so now you can dream and something like that, but before it is not at all.*

3. **Needing Government Leadership** – This theme reflected the views of participants who described their beliefs for the need of national leadership and government interventions to improve their situations, and to use their ‘power’ for helping people emerge from poverty. This is illustrated in the following excerpts:

[Male, Host, age 26, Themes: Needing government leadership, Despair] *He is saying that the feeling will not be well so they are not happy and he is saying that the government [should] provide them a job would be better or the company to open so they can get the job.*

[Female, Returnee, age 38, Themes: Needing government leadership, Despair] *They are hopeless. They are not happy. They are hoping the government will solve these problems and the government is not able…. So people are not happy and hopeless. So community have no power to do anything coz the power is with government.*

6.5.3 Participant perceptions regarding mental illness

The third research question honed in on how the interviewees perceived mental illness, its causes, symptoms and the types of treatments they access. This also involved an
examination of how communities responded to mental illness in their culture, attempting to ascertain community attitudes and sentiments towards people with mental illness. Table 34 provides a summary of the themes that emerged from the interviews, following with explanations and examples of those themes.
Table 34

Research question 3: Summary of emergent themes about community perceptions regarding mental illness

<table>
<thead>
<tr>
<th>Research question</th>
<th>Emergent themes</th>
</tr>
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</table>
| 3. What do people in South Sudan perceive as the causes, symptoms and treatment options for mental illness; and how do their communities respond to those with mental illness? | - Signs that someone might be experiencing emotional or mental health problems included Behavioural changes \((n=39)\), changes to Speech and conversation \((n=39)\), Social withdrawal and isolation \((n=15)\) and Other specific symptoms \((n=13)\)
- Names for people with emotional or mental health problems were: Unstable or not of sound mind \((n=8)\), Crazy, mad or wild \((n=30)\), Bad, dangerous or being without value \((n=15)\), No names \((n=8)\) and Traumatised \((n=1;\text{ returnee only})\).
- Causes of mental illness were attributed to: Life situation \((n=34)\), Thinking too much and being impatient \((n=30)\), Family situation \((n=12)\), Consequences of war \((n=9;\text{ mainly returnees})\), Health problems \((n=8)\) and Other causes \((n=7)\).
- Treatments for mental illness included Social support \((n=24)\), Practical support \((n=18)\), Medical care \((n=18)\), Prayer and traditional treatments \((n=16)\), No treatment \((n=11)\) and Government solutions \((n=9)\).
- Community reactions, or sentiments, regarding people with mental illness included: Commiseration \((n=12)\), Community responsibility \((n=35)\), and Impassiveness \((n=18)\). |

6.5.3a Signs of emotional or mental health problems

The first interview question, “What would be the signs that someone in this community might be having emotional of mental health problems?” derived from the Bolton,
Neugebauer and Ndogoni (2002) study. Interestingly, despite the returnee group having higher education and exposure to health services during their years of asylum, the data did not indicate any differences between the host and returnee groups in their portrayals of how they would recognise people experiencing emotional or mental health problems. The interviewees shared a range of themes, summarised into four categories; noting that many participants recognised multiple signs and symptoms in their feedback. The four themes identified included: Behavioural changes, Speech and conversations, Social withdrawal and isolation; and Other specific symptoms. When discussing signs of emotional or mental problems amongst people in their communities, participants often described the themes of behaviour change, speech and conversation difficulties and social isolation conjointly, albeit with different emphases. Therefore, the first three themes are described together with interview excerpts relevant to each of these community perceptions.

1. **Behavioural changes** – These involved both general changes to character and attitudes, as well as specific behaviours such as displaying strange or socially unacceptable behaviours such as walking naked or attacking/beating other people. They also mentioned increased alcohol consumption as an indicator of behavioural change.

2. **Speech and conversation** – referred to the ways individuals with emotional or mental health problems communicated differently. People with such problems were seen as confusing to talk to, argumentative, or frequently speaking to themselves.

3. **Social withdrawal and isolation** – captured people with emotional or mental health problems who were not engaging with others in the family or community in the usual and expected social manner, such as not being part of social gatherings or being unable to engage in conversation with others.
Female, Host, age 33, Theme: Behavioural changes] So she say that it might be that somebody can walk naked and sometimes he can take a stones, just throwing the stones to the people. Sometimes he is just talking alone.

Male, Host, age 30, Theme: Social withdrawal and isolation] There he is saying that the time of isolation. If someone is among us before and then he isolated himself among the people. The second sign is he is talking hushly to the people. He is not peaceful. He is not normal. And sometimes he can isolate himself and not come together with the people. So these are the signs.

Female, Returnee, age 40, Themes: Speech and conversation, Social withdrawal and isolation, Other specific symptoms] If he have a problem. So the sign is that he is a talking, not in a good way. He’s making quarrel, and then the behaviour is differently to the other people. The behaviour. He can be a troublesome or he can be a hushed to the people. He not talking in a good way. So he’s not thinking of good things so what he said is always negative; it’s not a positive things.

4. Other specific symptoms – The fourth theme described that signs that people in their community were experiencing emotional or mental health problems indicated additional specific symptoms, such as not eating, not sleeping well, being overwhelmed by hopelessness or unable to face the usual hardships of life. Only three participants suggested symptoms that might be related to trauma symptoms, such as increased startle or unjustified fearfulness. Once again, other themes (e.g., behaviour change or speech and conversation) were integrated with specific symptoms as overall signs of emotional or mental health problems. For example:

Male, Host, age 34, Themes: Other specific symptoms] … He’s afraid of people. At the beginning that we might discover that there is something wrong with this man.
Sometimes he develop the fear he can just jump up like if there is somebody attacking him, while there is nobody.

[Female, Returnee, age 38, Theme: Specific symptoms] So the other sign is sometimes it is certain people, it is difficult for them to sleep at night. So you see them, they are walking, going in there, coming out again and walking through the night without taking rest.

[Male, Returnee, age 39, Themes: Behavioural changes, Other specific symptoms] He can put himself in strange dress, or in the ladies dress or something like that so we might recognise that this man is affected by mental problems. So sometimes we cannot help. Cannot help out. And he cannot sometimes stay without taking food – give food if he is not eating.

6.5.3b Names for people with emotional or mental health problems

After determining how the interviewees ascertained the signs of people experiencing emotional or mental health problems, the interview used another Bolton, Neugebauer and Ndogoni (2002) question; “Do you have any special names for emotional or mental health problems?”. Responses varied considerably, including slight differences between the host and returnee groups. Returnees termed people with emotional or mental health problems in a more moderate way by indicating they were unstable or not of sound mind (returnee, n=7; host, n=1), while the majority of the host community dismissed people with emotional or mental health problems as merely crazy, mad or wild (returnee, n=13; host, n=17). For people referred to as mad, it was even suggested that they are no longer known by their family or given names; rather, just the label of a mad person.

For both groups, a number of interviewees reported that they did not have specific names for people with emotional or mental health problems (returnees, n=5; host, n=3) and several suggested that such people suffering with these mental health concerns were “bad”
people, or people who had become bad, and were therefore potentially harmful to others. There were even some local Shilluk or Arabic words that suggested people with emotional or mental health problems were potential killers, robbers or dangerous. This connotation that people with emotional or mental health problems were “bad” was possibly indicative of animistic beliefs that are common throughout the Sudanese tribal cultures (Kemp & Rasbridge, 2004), but may also have been based on a lack of understanding about the nature of mental illness, or some combination of these ideas.

Only one returnee suggested that people in the community with emotional or mental health problems were “traumatised”. Thus, in all, five main themes for how people labelled others with emotional or mental health problems emerged, which were:

1. Unstable or not of sound mind
2. Crazy, Mad or Wild
3. Bad, dangerous or being without value
4. No names
5. Traumatised

To illustrate the first two themes, the following excerpts show how participants described people with emotional or mental health problems as being either unstable/not of sound mind, or within the broad category of crazy, mad or wild; and in some instances, where they were no longer considered valuable or in need of recognition of their given names.

[Male, Returnee, age 39, Themes: Unstable or not of sound mind, Crazy, Mad or Wild] *So they are known as the crazy people. He just become what we call a person who is not sound in his mind. They could have their own names, but they could be given names because they are different mood or different situation.*

[Female, Host, age 62, Themes: Crazy, Mad or Wild, Bad, dangerous or being without value] *She is saying that the people have no name but some of the people are*
valueless. Yes, they have no value with society. Because they are like children, because they behave like children.

The theme that people with emotional or mental health problems were ‘bad’ was quite a strong theme with many generalisations made by the participants, and could be interpreted in a range of ways. For instance, if a person is termed as ‘mad’, they are also termed as potentially dangerous, going so far as to suggest local terms like Anak (Shilluk for “male killer”) or Nydhanak (Shilluk for “female killer”). In addition, some participants simply explained such people as ‘bad’, without such strong connotations of violence or danger and indicative that something negative had occurred in the minds of those people – rather than suggesting they were ‘bad/evil’ people at the core. Nonetheless, whichever way people with emotional or mental health problems were described, it was largely negative, with minimal suggestion that people with these problems might require compassion or care. Excerpts to describe these ideas include:

[Male, Host, age 34, Themes: Crazy, Mad or Wild, Bad, dangerous or being without value] So they called mad people. So he is termed a mad man…. So when we call him one, up in Shilluk, so it is termed as a killer. Yeah. Anak is a killer. Anak. He’s a killer by himself. But when we translate it, it become a killer. So the disease is termed as a killer because that person can kill and kill somebody, or can be killed. Yeah. So called Anak.

[Female, Host, age 28, Themes: Crazy, Mad or Wild, Bad, dangerous or being without value] So he’s called a mad man. Or if she is a lady she is called Nydhanak…. So the mad lady.

[Returnee, Female, age 38, Themes: Bad, dangerous or being without value] There is no real name but we term them are the bad people. Yeah. Because they can attack you while you are just walking on the road or they can do something bad against.
There are some names, which might not term them as a mad people, or mental people, but create another name. A Betinoyme [phonetic spelling]. So they be happier by robbing people. They come at night with the guns and then collect things. If people go to the forest to collect the firewood they can attack people taking their clothes or whatever they have. Yeah. They are violent.

[Female, Host, 20, Theme: Bad, dangerous or being without value] So, we call it sometimes people with a bad mind, or bad thinking. Yeah. So his mind become bad. People with a bad mind or bad thinking.

As previously mentioned, only one participant suggested that people with emotional or mental health problems were “traumatised”. Importantly, this participant was a returnee, had undergone some form of training, and thus appeared to be using English words and ideas to describe people in his community with emotional or mental health problems. In contrast, all other participants in the research had more local, traditional and cultural perceptions about emotional and mental health problems. This participant stated:

I think, mostly, in the, in some kind of training we find that ah, we say it in some kind of people we say ah really, traumatised, is the very special word that we use for such people, OK. They are really traumatised. Always we are blaming war. They are really traumatised because of war in the south.....In fact, by addressing these problems, these factors, we can really heal some of this.

6.5.3c Causes of mental illness

Building on the third research question about what people in south Sudan perceived to be the causes, symptoms and treatment options for mental illness, the next interview proceeded to draw from the DSM-IV-TR (APA, 2000) Cultural Formulation, asking respondents; “in your opinion, what causes emotional or mental health problems?” They
identified six themes, however, for the most part, they were all linked to the construct of lacking in basic needs. The six themes identified from participants responses were:

1. **Life situation** – This captured beliefs that poverty, hunger, lack of property, low education, stress due to their living conditions or the inability for parents to provide for their families were major causes of emotional or mental health problems in their community. This was a common theme amongst both the host and returnee groups.

2. **Thinking too much and being impatient** – Participants commonly described a cause of emotional or mental health problems as being linked to individuals who literally thought about their problems too much, thought about their hopes and wishes for the future too intensely and linked to this, became impatient for attaining their needs or wishes. However, the issues people described as thinking too much about were often linked to basic needs, where people described others in their community wishing to live in a different situation. Nonetheless, this concept of being impatient and thinking too much was evident in the interviews and implied that the participants believed individuals ought to be more realistic about their lives and not deliberate on what they did not have. Interestingly, this was a theme more common within the host sample group \((n=18)\) than the returnee group \((n=12)\).

3. **Family situation** – Many people believed that difficult family situations, such as lacking familial support to help people access their basic needs, or having poor extended or parent-child relationships was a possible precursor to emotional or mental health problems.

4. **Consequences of war** – Participants, particularly the returnee group \((n=7)\) compared with the host group \((n=2)\) identified that the consequences of the war was linked to emotional and mental health problems. Although some participants identified ongoing insecurity and fear of returning to war as emotional consequences that may lead to
emotional or mental health problems, most participants related the consequences of war back to how it had influenced their lack of basic needs, including economic and property opportunities.

5. **Health problems** – Some people believed that lack of medical care was a likely cause of emotional or mental health problems, where untreated medical conditions could lead to mental illness. However, the predominant medical condition believed to cause mental illness was malaria. While the high fevers associated with malaria can induce secondary psychotic symptoms, these usually subside once the malaria fever has been contained (Collins et al., 1999). Cerebral malaria is associated with severe neurological side-effects, though this form of malaria usually results in one of two outcomes – death or treatment and recovery with minimal lasting neurological symptoms (Thi Hoang Mai et al., 1990). Nonetheless, it was interesting to note that within the current sample, such symptoms of severe mental illness (albeit secondary to a medical condition) were linked to being causal amongst this community with minimal access to medical care.

6. **Other Causes** – A range of ‘other’ possible causes of mental illness were identified, albeit with less emphasis than the aforementioned themes. The host community identified witchcraft as a possible cause for mental illness. They also identified the loss of loved ones as another possible cause, with views that complicated grief may be indicative of longer term emotional or mental disorder. Only one participant thought about the inheritability of mental disorder.

As with previous themes, multiple possible causes of emotional or mental disorder were evident in the responses to this question. Following are some excerpts of each of the six themes, though not mutually exclusive:

[Male, Host, age 23, Themes: Life situation, Thinking too much and being impatient]

*The causes of these are the interests* **might be you need a something and you fail to**
get it. And also the environment where the people live. So if the people are fighting throughout it might let a person feel not a happy if there is a quarrelling from time to time…. People of course are different. There are people who are quick who they think he want to get things very quickly, and then there are those who are patient. So if he determines to get something so if he is patient that there is nothing, so that if he wait, that one day he might get. But other people, they are not patient, they are in hurry, they want to get it and if they fail, then medically it might cause a problem.

[Male, Host, age 23, Themes: Thinking too much and being impatient, Other causes]
A lot of thinking. So you can be thinking to do something then you put your hope that by that time I will achieve this; so if the time come and you are not able to do it, then mentally, it causes the mental problems. So there are people who, who might be able to endure this situation and there are some who might not be able to endure the situation. Another thing also, there are certain things which is connected with the traditional magics – or witchcrafts. So people sometimes believe that these are the causes of mental.

[Female, Returnee, age 27, Themes: Family situation, Health problems] So she is saying that the life she is can causes a problem because her father is not there to support her, the husband is not there, so she is disturbed from time to time. If there is sickness or if there is anything, it can causes mental problems.

[Female, Host, age 50, Themes: Other causes, Consequences of war, Life situation] She is saying these problems sometimes it can be inherit. Because a family with a person in it can be inherit. Also, can be causes by the war within the country. Or also, lack of resources, if you have nothing sometimes you got to your neighbour and if he get a better life and you want it, then it can develop into something. So previously when there was a war, she is saying that it was being better than the
present situation because of the time, people were afraid of death, because there is a fighting throughout. So now there is a peace and everybody want to get a job. And is not able to take a job.

[Female, Host, age 39, Themes: Other causes, Health problems, Life situation] So of course it is different because the reasons are not clear, but it might be someone’s children died, or it can be caused like that. Or it might be a sickness sometimes, or it can be the needs; the needs and they fail to get them. So they differ from person to person. She is saying that sickness sometimes be just as termed as malaria, it might cause a mental problem.

6.5.3d Treatment for mental illness

Continuing to follow the Cultural Formulation of the DSM-IV-TR (APA, 2000), and the third research question about causes, symptoms and treatments for mental illness, the next interview question related to how individuals and communities would respond to people who needed mental health care. In response to the question “How would you go about finding treatment for someone with an emotional or mental health problem?”, participants’ responses resulted in six distinct themes:

1. **Social Support** – Participants described the importance of personally caring for people with emotional and mental health problems, such as listening to their needs, encouraging them, and bringing them back to their communities for care.

2. **Practical Support** – Many expressed the importance of trying to practically support others with emotional or mental health care needs, by helping them to access their basic needs, employment, food, shelter.

3. **Medical care** – Many recognised the role of medical assistance in treating people with emotional or mental health problems, particularly indicating doctors, the local hospital, or even professional psychiatric treatment in northern Sudan (Khartoum).
4. **Prayer and traditional treatments** – As a predominantly Christian tribe, many interviewees indicated the importance of prayer for people with emotional or mental health problems, and many believed in traditional tribal interventions. Either way, these two approaches were considered important and discernible local traditions.

5. **No treatment** – Even among participants who believed prayer, practical or social support or treatment from medical professionals were possibilities for treating people with mental disorder, a number believed that some people with such conditions were simply not treatable, and that either they would not be able to offer assistance, or that there were limited options and once these had been tried (e.g., doctors), if the problems persisted, they would abandon hope for their cure or management.

6. **Government solutions** – Some participants believed people with emotional or mental disorders needed to, or would be better assisted, if they went to the government prison \((n=4)\) where, at a minimum, people are likely to receive two meals per day and be engaged (thus not ‘idle’) in other activities. The remaining responses with this theme \((n=4)\) were those who believed it was solely the responsibility of the government to care for people with emotional or mental disorders; but only returnees appeared to hold this belief, with some expressing quite derisive or paranoid attitudes toward the Northern Sudanese government and people exhibiting emotional or mental health problems (e.g., “So the problem, she says, is how to treat such a people is very difficult, because they [people with emotional or mental health problems] have a connection with a northerners, who supply them [with guns] in order to disturb the peace. So except if there is a separation of the north and south, there might be such a thing [as people with emotional or mental health problems], it dies out”). This is likely to link back to participants who believed in the potential harmfulness and violence of people with emotional or mental health disorders.
Similar to previous qualitative data, participants outlining concepts of social support, practical support, medical care or other themes related to accessing treatment for people with emotional or mental health problems, the following excerpts describing these themes incorporate multiple ideas and options, but are reflective of each thematic category outlined above. Examples from the participants about how they would find treatment for someone with an emotional or mental health problem include:

[Female, Host, age 40, Themes: Social support, Medical care] So the treatment is that we need to care for a person if he is in need of support – and support him. Bring him in the community and make conversation with him. Sometimes if he gets the doctors he is better.

[Male, Host, age 22, Themes: Practical support, No treatment] So sometimes if they are given jobs or if he is a problem of marriage and then he can be support by his family to marry, so sometimes they treat the problem. So if the people try to do something with his problem and he still continue, he is left as a mad man. There is no alternative.

[Male, Returnee, age 40, Theme: Social support] So he’s saying that he need to be brought near to the people, to be accommodated by the people and be advised. And also that if only for certain words.

[Female, Host, age 33, Themes: Prayer and traditional treatments, Medical care, Practical support] So there are two types of treatment. There is a traditional treatment and you send them to a magician man. And another one can be in the hospital. And also, if it is there is a need and if the need is met, then also there is another treatment.

[Female, Returnee, age 38, Theme: Prayer and traditional treatments] So many people, it is difficult to find a treatment for them. But they need to be encouraged and the
people pray for them, and they need to be told that the situation is a common for the people and they need to be taken to the church and the people can pray for them.

[Female, Host, age 39, Theme: Government solutions] So she’s saying that they need to be taken care of. Or sometimes they can be collected and put in prison and then they are engaged to other activities. So they are advised and given work to do, instead of staying idly.... So they can be engaged and be cared for by the government sometimes.

[Male, Returnee, 42, Themes: No treatment, Government solutions] He’s saying that nobody can solve these problems except if it is a government who can take a responsibility of treating them, but nobody is able to take the responsibility for another person.

6.5.4 Community responses to people with mental illness

Within the third research question (refer to summary of results for research question 3 in Table 34, p.193), the final enquiry was taken from the DSM-IV-TR (APA, 2000) Cultural Formulation and considered the broader community responses to people with emotional or mental health problems. The specific question asked was: “How does your community react if someone has serious emotional or mental health problems?” Many participants responded to this question similar to the earlier question about what treatments they would seek for people with emotional or mental health problems. Their responses followed the same themes outlined in the previous section about treatments for people with mental illness, and again noted that they would respond by facilitating or providing social support (n=18), practical support (n=8), medical care (n=11), prayer or traditional treatments (n=13), no treatment (n=18) or seeking others, like the government or local justice system to provide care for those individuals (n=8). Interestingly, when participants considered treatments for individuals,
only 11 respondents believed there was no treatment for emotional or mental health problems. However, when asked about community responses, more people \((n=18)\) expressed the idea that no treatment was available or effective for treating such cases. This is possibly a more accurate depiction of the local perceptions about the community’s capacity to assist people with emotional or mental disorders. There were not any distinguishing differences between the host and returnee group ideas, thus the overall community sentiment towards people with emotional or mental health problems was described by three main themes. These were:

1. **Commiseration** – This theme captured views of the community as being unhappy about people amongst them living with mental disorder. They expressed their sympathy, sadness and at times, a loss of a person who was no longer part of their community.

2. **Community responsibility** – Most interviewees indicated that the community had some type of responsibility to work towards supporting people with emotional or mental health problems, usually by coming together and finding ways to facilitate them in receiving treatment of some kind. Participants who referred to a sense of community responsibility spoke a great deal about the importance of providing such individuals with *encouragement, advice, practical care and support*.

3. **Impassiveness** – Many participants believed that people with emotional or mental health problems ought to be simply left the way they were, ignored, removed from community involvement (e.g., shackled) or given to others to care for, such as put in prison and cared for by the government. This concept of impassiveness was not always immediate however, as many participants suggested that if treatments, such as community care, advice, medical care or practical support, were ineffective, then they had no other options but to cast aside their sense of sadness and/or community responsibility and leave those individuals untreated or uncared for. This theme was labelled ‘impassiveness’ because
participants’ descriptions of such approaches were detached and matter-of-fact, with little reflection upon such a situation being a difficult or emotive one.

The responses that identified the three themes of Commiseration, Community responsibility and Impassiveness were sometimes reflected singularly and at other times, with multiple themes reflected in their statements. Therefore, many participants’ responses were counted in more than one of these three themes. The following statements provide examples of these themes:

[Female, Host, age 26, Themes: Commiseration, Community responsibility] So the community might feel not comfortable coz one day he was a good person and then he become a having a mental problem. So people sympathise with the situation and then if there is any support, help.

[Male, Returnee, age 33, Theme: Impassiveness] So he just released. That if somebody is left like that, a mad person, so nobody would care about him. So he is not given advice sometimes.

[Female, Returnee, age 27, Themes: Community responsibility] She’s saying that you can put him down and advise him. So the community control him so that he might not run way. Sometimes people tie his hand in the house, his legs and hands are tied and then seated. Or sometimes he is taken to the prison or people visit him from time to time.

Another salient feature of this question was the notion that a few participants (n=3) believed that mental illness was either contagious or that each person had the potential to be affected. The following excerpt provides an example of this:

[Female, Returnee, age 38, Themes: Commiseration, Impassiveness] So the reactions of the communities is different. So those who are believers, they sympathise with the situation, but those who are not believer, they just laugh, laugh at him, as a failure.
So nobody care for them, **everybody is worried for himself that they will be like that man.**

6.5.5 Perceptions of control and views of the future

The final component of the qualitative analyses related to the fourth and fifth research questions about whether the participants felt they had a sense of control over their lives and to ascertain if they had reported feelings of hopefulness and capacity to plan for their futures. Specifically, the qualitative analysis also sought to determine if there might be differences between the host and returnee groups of participants given their experiences of migration differed. A summary of the themes that emerged from the enquiries related to research questions four and five are provided in Table 35.

Table 35

**Research questions 4 and 5: Summary of themes related to feelings of control and views of the future**

<table>
<thead>
<tr>
<th>Research question</th>
<th>Emergent themes</th>
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<tbody>
<tr>
<td>4. Do participants view themselves as having some autonomic control in their lives?</td>
<td>- Autonomy (n=29)</td>
</tr>
<tr>
<td></td>
<td>- Dependence (n=15)</td>
</tr>
<tr>
<td></td>
<td>- Uncertainty (n=7)</td>
</tr>
<tr>
<td>5. How do participants view their short term and long term futures and is this influenced by their current situation?</td>
<td>- Life in 2 years: Hopefulness (n=24), Unknown (n=21), Comparable (n=3), and Pessimistic (n=5).</td>
</tr>
<tr>
<td></td>
<td>- Life in 10 years: Hopefulness (n=25), Unknown (n=24), Comparable (n=0), Pessimistic (n=3)</td>
</tr>
<tr>
<td></td>
<td>- Considerable gender differences in views of the future were observed.</td>
</tr>
</tbody>
</table>
6.5.5a Autonomic control

First, to assess whether the participants felt they had some control in their lives, they were asked the simple question; “Do you feel like you have control over what happens in your life?” Three pronounced themes emerged from the responses. Many reported feeling a sense of control with regard to what happened in their lives, but the returnee group (n=17) tended to experience this in greater proportions to their host group (n=12) counterparts. Another disparity was apparent in the data as well, with more men in both groups reporting feelings of control in their lives than women (men, n=18; women, n=11). In contrast, for those who did not feel a sense of control about what happened in their lives, the host group (n=10) tended to indicate a greater dependence on other factors than their returnee counterparts (n=5); and women reported considerably more feelings of dependence than men (men, n=5; women, n=12). For both groups, a similar number of participants reported uncertainty about whether or not they had control over what happened in their life, indicating that some things were within their control while others were not. For each of the three themes, participants justified their beliefs in autonomy, dependence or uncertainty in a variety of ways, which is further explained in a description of these three themes. Although there is a broad psychological construct called autonomy, particularly within the Self-Determination Theories of motivation and behaviour change (refer to Deci & Ryan, 2008), autonomy in this research was only used as a general and descriptive term as it relates to feelings of control, self-sufficiency or independence.

1. **Autonomy** – Interview responses that were thematically categorised as having ‘autonomy’ were the participants who expressed some feeling of personal control in their lives, or the capacity to take an action that would enable them to achieve a feeling of control. Some participants reported this as being a simple question with a simple response (e.g. [Host, Male, age 30] “So he’s able to control what might happen in his life”)}
life”), while others believed they were able to achieve such control through prayer, simple problem solving techniques or endurance. For example:

[Male, Returnee, age 41, Theme: Autonomy] The answer to that question is because he has a problem, he can control it, so he say yes. He pray to God and seek help through prayer.

[Female, Returnee, age 40, Theme: Autonomy] she is saying yes, she is able to control what happen in her life. If it is anything that happens it is a part of life. It need to be endured and it need to be solved.

2. Dependence – This theme referred to individuals whose responses, or the sentiment of their responses, suggested that they had no sense of personal control in their lives; rather, they were dependent on other factors who had ultimate control. For the participants who believed they did not have control in their lives, they predominantly attributed this to other people, God or unexpected events precluded them from having control. Although in the previous theme, some participants believed they had control in their lives through God and through prayer, participants in this group believed God was all controlling. Other participants reported factors like having being jobless or having no money left them without autonomy. For women in particular, they spoke about being dependent on other people, particularly their husbands or other male leaders in their lives. Examples of participants reporting dependence on other factors as being causal for their lack of control were:

[Male, Host, age 25, Theme: Dependence] Of course no. He cannot manage to become or control the problem that happen to him. It’s God alone who can manage to fix the problem. He does not manage it himself.
[Female, Host, age 30, Theme: Dependence] She says she is not responsible for anything that happen in her life. The husband is the one responsible. She said her father also.

3. Uncertainty – This theme reflected the participants who believed that there were some aspects of their lives they could control and others they could not. These participants did not attribute cause to what was within their control what wasn’t, but they reported a succinct belief that they were able to contribute to controlling some aspects of their lives, but not others. For example:

[Male, Host, age 23, Theme: Uncertainty] So if something happen sometime, if it is when he can solve it; but if it is very big it will be difficult to be solved. The smaller things he mention is like a hunger. Hunger you can go and a borrow, so it can solved, or you can go to your brother and he can help you. But the problem of having the permanent place or building where he can live permanently is a bigger thing that cannot be solved easy...

6.5.5b Views of the future in 2 years

To examine the final research question about participants’ views of the future, interviewees were asked two questions adapted from Marshall and Arvay’s (1999) study. Specifically, they were asked about how their perceived their lives would be in 2 and 10 years’ time. In response to the first futuristic question, “When you think about your future, how do you imagine your life will be in 2 years’ time?” there were no major differences between the host and returnee groups. Both groups reflected on the importance of reigning peace, better living conditions and God contributing to whether or not they felt they could be hopeful for a better future. Some also indicated that the future was dependent on them surviving the next 2 years.
Despite no differences between host and returnee attitudes towards the future, women and men differed considerably. Women tended to be more uncertain about the future and men expressed some feelings of hopefulness. Overall, two themes were generated about the future in two years’ time; Hopefulness and Unknown. Two secondary themes also emerged in the data with three participants suggesting the future in 2 years’ time would be Comparable to the current situation and five participants suggesting a Pessimism about the future and/or a feeling of not daring to be hopeful about the future for fear of being disappointed or troubled by wishing for a better life. The following sections outline these four themes in greater detail and provide qualitative examples of how participants reported them.

1. **Hopefulness** – This theme reflected the participants who felt they had good things to look forward to in the future and a sense of positivity about life in two years’ time. It was mostly men who expressed a sense of hopefulness about their future. These participants believed that if peace remained in South Sudan, they continued to experience freedom of movement, they had opportunity to pursue their education and careers, and were blessed from God, then they expressed a sentiment of optimism about their futures. The following participant statement reflects these ideas:

   [Male, Returnee, age 40, Theme: Hopefulness] *So he’s thinking that it will be better because it is not like a time war. So anybody, he can go without any lack, without security problems; so he is thinking that it will be more better.*

2. **Unknown** – Interviewees that reflected a sense of unknowingness about their futures acknowledging that whether or not their lives would be better was dependent on many factors, including peace and being able to meet their own needs. For the most part, participants classified into this theme could not express a notion of futurism in their responses. Though many of their statements leaned toward a pessimistic view of the future, they tended to be more uncertain than worried about the future and unwilling to
engage in an imaginative exercise of this type, as though thinking about the future was a risky thing to do. Just over half of the women in the total sample group (14 out of 26), plus seven men, described the future in two years’ time as unknown and uncertain. Women were clearly more reserved than men in thinking about the future. Also, one woman in the host group expressed uncertainty about whether or not the returning Southern Sudanese from other parts of the country and world was a good thing or not, as follows:

[Female, Host, age 50, Theme: Unknown] So she cannot determine what will happen after two years so she might change or she will come in like that so she does not know. But the good thing is that there is a peace and some people were away, so she welcome them back; for the people who were away for many years. So she is not sure if that will be a good thing or not.

3. **Comparable** – This theme emerged from interviewees who indicated that they did not believe their lives would be any different in two years’ time as it was now. They were short and concise in their responses, believing life would be neither better nor worse, albeit with one woman reflecting that this was perhaps due to there being minimal hope in the past and similarly, minimal hope in the future; and another woman acknowledging greater education for her children, but no change for her. It was only three women who took this pragmatic view of believing the future would be comparable to the current day. Two of these responses were:

[Female, Host, age 20, Theme: Comparable] So she is saying that there is not hope so the coming years will be the same as these years.

[Female, Returnee, age 30, Theme: Comparable] She will be staying as she was before.
4. **Pessimistic** – Although only a small number of participants reported feeling pessimistic about the future, their responses were quite distinguishing in their tone and reservation about the future. Those who expressed pessimistic views of the future in two years’ time were especially sombre in their views about the future. Their sense of pessimism commonly surrounded concerns about their aging bodies, death and in one woman’s instance, a desire to not wish for good things in the future as hopefulness may generate further problems. This group consisted of only two men and three women. An example from this group was:

[Female, Returnee, age 38, Theme: Pessimistic] So when she think about the future she say that sometime she think it might be difficult to reach 2 years, because there is no happiness in her life. She is tired from time to time with children. But with God’s grace she think it is OK. She has connected with her faith before, but she think she should not be alive in the war or survive; she think of being dead.

6.5.5c Views of the future in 10 years

Despite struggling to respond to an image of their future in two years’ time, the interviewees were stretched by the final question that asked them; “How do you imagine your life will be in 10 years’ time?” A number of participants laughed at this question (n=7), but surprisingly, their responses did not necessarily differ to the concept of future thinking from just 2 years. It appeared that the fancifulness of a 10 year future question intrigued the group and for the most part, they expressed either hopefulness about the future (n=25) or uncertainty/unknown (n=24). Interestingly, none of the participants believed that 10 years into the future would be comparable to the present day; however three women from the host group did continue to report feelings of pessimism about the future. Also, in a similar pattern to the previous question, there were no marked differences between the host and returnee groups and men were still reporting greater hopefulness than women (men,
n=17; women, n=8); while women continued to be more pragmatic and more likely to state the future as being Unknown (men, n=10; women, n=14). Also, in a similar pattern to the responses to the first 2 year future question, participants still responded to the 10 year future question with the conditions of peace prevailing in South Sudan, basic needs becoming easier to access, and God blessing them to live the full 10 years to which the question enquired. The following excerpts reflect the three remaining themes from future thinking, with one example each of Hopefulness, Unknown and Pessimistic.

[Male, Returnee, age 40, Theme: Hopefulness] **It will be much better.** So he’s hoping that at that time he might be stable. He will have durra [sorghum], he can go and cultivate the durra or he will have a the goats and cows and maybe he can have a fishing net. And he will have a good place where he might stay with his children, and his children might also have a school. **He will have something in his hand.**

[Female, Returnee, age 40, Theme: Unknown] **So she is thinking that she might be an old woman because her age will increase.** And how might her life be then? **So she cannot imagine what will happen, maybe she can be a cripple woman, so she don’t know if she is OK; she cannot imagine** [laughing].

[Female, Host, age 50, Theme: Pessimistic] **So she has children who tell her that in 10 years she feel like a child cause she will be quite an age then will have no hope.**

6.5.6 Observations and additional comments

As outlined in the general Method chapter (Chapter 4), notes were made by the researcher regarding those participants that showed interesting, unusual or salient behaviours throughout the interview process. The vast majority of the participants appeared relaxed and at ease with the interview process. However, the following anomalies were recorded by the researcher.
Five of the participants (three women and two men) showed marked difficulty responding to the interview questions. For two of the participants, they struggled to use the concept of “in the past week” when responding to the questionnaires, and two participants also struggled to respond directly to the interview questions, preferring instead to simply share their personal stories or their personal opinions about matters related to the war, the political context or status of returnees. One participant, a returnee aged 41 years, had a specific preoccupation with trauma after reportedly reading about it during his time in Khartoum. Another male participant had extreme difficulty distinguishing the past and the present, commonly conflating the two time periods in his responses. As a returnee, he struggled to separate life back in South Sudan in the present day and life in South Sudan before he had left as an internally displaced person. For example, when speaking about common problems affecting the community, he raised concerns about the Arab influences in South Sudan, including sexual violence against Sudanese women, but it was difficult to clearly ascertain if he was referring to the present situation in South Sudan, his experiences in asylum when living in Khartoum, or both. The following excerpt from this returnee’s interview demonstrates his conflation and difficulty articulating past and present experiences:

[Male, Returnee, age 41] Sometimes they [the Arabs] focus just the ladies, they caughting [catching] them, just to change the colour. The culture, the ladies and then they took them by force as their wife so that they bear the children, which is likely to be Arab. [Researcher Question: OK. And this activity is going on here in Upper Nile? Today?] Yes. Yeah. It was happening even when we were up in Khartoum. [Researcher Question: OK. So it started where?] It started from here [South Sudan]. And then outreach of the town [referring to Khartoum], because all of the areas outside were being occupied by the soldiers of the government [referring to war time].
Eleven participants were challenged with the emotive content of the research interview. Those with particularly affective presentations were nine women and two men, ranging in their degrees of emotionality. For the women, a number presented as extremely shy, with two others speaking with extremely blunted affect. Some were quite reserved and reluctant to speak, possibly due to the presence of the male translator. The two men displayed emotions during the interviews by being very reserved, serious and succinct in their comments. Two women and one man cried during the interview, with one woman particularly distressed. Despite these expressions of emotion, in all instances where the participants were showing sadness, shyness or timidity, they never asked for the interviews to cease, nor accept the researcher’s offers to end the interview. Notwithstanding their emotions, the participants appeared to want the opportunity to speak about their concerns and their lives.

Finally, the researcher noted three other participant presentations that were unusual. One woman (host participant, age 39) spoke rapidly with what appeared a pressure of speech; another female participant (returnee, age 38) was physically agitated throughout the interview while the third was a returnee woman (age, 26) who presented and responded to questions in a very business-like manner, carefully formulating each response.

Although the research observations were minimal and for the most part, inconsequential, it was notable that the sample group exhibited a range of presentations that contributed to the diversity of responses to the open-ended qualitative research questions. Even though the majority of the participants presented with no distinctive emotional responses, and engaged easily with the researcher and translator, it was a methodological strength of the research and sample group that there was a range of experiences represented. It demonstrated that men, women, host and returnee participants of many ages were all experiencing different degrees of tolerability with the interview process and a range of
emotional intensity when thinking about their past, present and future situations. As such, these variations of observations about participants could be adequately indicative of the diversity of individual responses expectant in many random community sample groups.

6.5.7 Key informant interview

As outlined in the Method (Chapter 4, p.81), a key informant interview with the translator was conducted following interviews with the host and returnee participants. This interview provided an opportunity to clarify some of the common topics raised in the data collection process and to confirm some of the local Sudanese customs that may have been relevant to the post-war context. Most notably, the translator confirmed that the local practice of wife inheritance and polygamy was a social norm that had been impacted as a consequence of the war and persistent poverty, as indicated in the following conversation:

Yes. *If the inherit man is in a good financial position then he can provide* [for the inherited wife and her children], *but if he is poor, so it is very difficult.* [Research question: Most of our participants had only one wife, or were only one wife…. Is that more common than multiple wives…?] Yes, *of course, a multiple or many wives is previously before the war. But now there is a war so people are afraid to keep many wives. But having many wives is common….. but it is the life situation or economic problems.*

Another reflection by the translator regarding the impacts of the war and the poverty in which participants lived was in relation to how local people generalised their views of the future. The translator implied that future thinking was unimaginable, because individuals were simply too focused on survival, which had become part of their living pattern throughout years of war. The following excerpt describes this:

*Yes, because there is no future planning due to the life situation they are living in.*

*Because they spend almost 20 years in war feeling hunger and lacking everything.*
So now it become addicted in their life, so they have no hope for the future. Because for the future it might be if you receive a good salary and you save some money that is where you might think what to do. But even the salaries are not enough to save some, that is why they don’t dream about the future. They are thinking that the life situation might continue like this. So because they are not saving anything, even the food, what they get, is not enough for the food, yes. So they build a just hut after two years or three years it fall and then they just build the same local because of lack of money, but if they have enough they can think.

The participant interviews did not indicate substantial concerns about the reintegration of the returnee group to their homeland, so this was explored further during the key informant interview. The translator agreed that there seemed to be no conflict or distinctions between the host and returnee groups, as both were struggling with similar concerns. Nonetheless, a reflection on returnees’ possible disappointment about what the homeland had to offer was verified, with the translator agreeing that many returning Sudanese had higher expectations for the peace accord. The following exchange describes these reflections between host and returnee perceptions of life in South Sudan at the time of data collection:

[Researcher question: How do hosts feel about returnees and is there ever conflict between them?] Ah, no conflict yeah. They are living in the same situation….. Those who are recent returnees they experience the problem in where they were and those who are in [the host group] they experience the same problems. So they are in the same situation.

[Researcher question: I did get the feeling though that returnees had slightly higher expectations of what life would be like here. I think they expected that they would have more property, more support, more assistance and obviously that’s not happened. Why do you think they have those expectations?] Yes, because there is
enlightenment given to them from where they come, that there is a peace. And that they are coming to do this and this. So when they came they are expecting that there is the real peace so that they can do the work by themself. But those who are in [the host community], they experience already that there is no school fees, because there is fighting from time to time. Because they [the returnees] are new now. Like what happened recently [referring to a recent border skirmish] some days back, so they might see that there is still a problem. But when they are outside they might think that there is no war and no problem.

The key informant interview provided additional opportunity to examine some of the local customs referred to by the participants during the qualitative interviews. The translator explained in more detail local perceptions of social support, including reasons why people did not commonly discuss internal emotive states (feelings) as well as why individuals commonly avoided discussion of the past.

The translator confirmed that local custom tended to promote greater social support from outside the family, such as with friends. This was linked to the processes of marriage, where the wider families of a married couple often maintained their own ‘family secrets’ – and thus, the relationship with friends for Sudanese people was generally perceived to be more open and had potential to be an supplementary source of material support, particularly when the family unit was unable to meet specific needs. The following exchange described this pattern of friendship relationships being commonly more socially supportive than family relationships:

[Researcher question: Why wouldn’t a husband and wife talk together about family concerns?] So they consider that the lady is brought from her family, so the woman is consider as a property of the man so she has no right to share her idea. Because you bought her by the cows. So she’s consider as a daughter of another family, so
the secret of family cannot be explained to her. [Is it fair to say that most people would rely more on their friends for emotional support than on their family?] Yeah, yeah. If you have a good relationship with your friend he can hug you mostly than your family. Because, so tomorrow you could go to your friend and say I am lacking this so he can give you. It is a matter of sharing, yeah..... Yeah, the friendship is more important than the family. Because you might have a problem with your family, but with your friend, I think there is no problem. That is why they concentrate on friendship more than the family.

Despite social support from friendship relationships being considered more open and giving than family relationships, the translator reported that such relationships were rarely predicated on mutual sharing of feelings, thoughts or past experiences. The translator indicated that individuals who shared feelings were considered weak and experienced shame for being unable to resolve their personal problems. This was complicated by local custom perceiving that feelings and thinking were the one construct. For instance, the Sudanese do not view a separation of feelings and the mind. Therefore, if you share sadness or distress, you are revealing to others a troubled mind, and admitting that you are unable to solve your problems. Being unable to solve your problems and describing to others a confused or distressed mind would likely lead people to perceive you as developing or having “mental problems”, and these perceptions cycle to generate further embarrassment or shame. At the same time, the translator confirmed that sharing past experiences of difficult times, such as sad stories of loss or trauma experiences from the war, was not considered helpful, with local custom dictating that there is little benefit to regurgitating the past given its risks for causing continued misery, difficult feelings and distress.

These findings shed light on why the vast majority of participants in this study did not discuss specific feelings, share challenges of having lived through decades of war, and why
they so commonly attributed “mental problems” with being unable to meet their basic needs. Avoidance of the past was also reported as a coping strategy; a way for individuals to keep their minds safe from becoming “mental”. The following extended excerpt from the key informant interview illustrates these ideas – beginning with confirmation that speaking about feelings is not a social norm, followed by statements that describes the dualism of feelings and mind and concluding with the translators remarks about why people in South Sudan deliberately avoid conversations about past suffering and the implications that doing so may, according to local tradition, prevent people from coping with their present fight for survival.

[Researcher question: … is it culturally appropriate to talk about feelings in any situation?] Of course, according to the culture it is, the feelings are hidden agenda, they are supposed not to be discussed….It is a nature of the people. Because they say that how can you explain your feelings to somebody else. Maybe he is not able to solve them or if it is a good feeling also he might detect them and then use them. So that is why the feelings is not shared…. Yes, traditionally it is shameful…. So it is like you are exposing your secret to the people. Yeah. That is why people are afraid of that. Or termed it that if you are not able to solve your problem by your own, why do you take it to the people?

Yeah, according to tradition of course, the bad things come from mind of somebody. Bad or good is from mind. That is why they term it sometimes a mental problem, its mean sometimes that the mind is spoiled, there is something wrong there.

[Researcher question: OK. And is that related to feelings?] Yes, of course, the centre of feeling is the mind. Yeah. It is the mind who can think or feel like that.

[Researcher comment: You see we would say that was different. So we would say that the mind is for thinking and the heart is for feeling.] So no, for us, the feeling… the centre of feeling is the mind. [Researcher question: OK. So if someone
has all these feelings going on in their mind, and they are thinking and thinking, and they’re not meant to share them, how do they get release?] That is why they develop into mental problems because they become chronic in the mind…. So that’s why we heard from the people that if they think a lot, then it can cause a headache. So because there is no solution for them, they become a chronic in the mind and then mind it give them to the eyes sometimes, some say that they cannot see.

[Researcher comment: I was fascinated that out of 53 people we spoke to, very few actually mentioned specific war time experiences.] Yes, it become a part of their life so they might not remember, so except sometimes if you remind him that there is accident like this. Because maybe, it is because, it become a part of life, the war, but there are horrible wars that happen so they might forget it. Because they are talking about example of war, but there are many terrible wars that happen before. Maybe they forget it....

[Researcher question: Why do you think people have trouble remembering the past the past, or reflecting on the past?] Yes, because of the life situation people are in, so it is difficult to remember the past because they are thinking about their daily need, mostly than the sort of other things. [Researcher question: So do people often talk about the past?] Yes, they talk about the past, but the horrible things they don’t talk because it might create the fear in them. So they avoid talking about the past things which can led them think about it again.

Providing further clarity regarding social relationships and Sudanese customs about how people respond to emotional experiences, the key informant interview with the research translator also shed light on some of the complexities around local perceptions of mental illness and how people sometimes managed these difficulties. Three particular areas were prominent. First, the translator noted the challenges surrounding the minimal vernacular for
mental health concepts in local languages. Second, the concept of suffering and mental illness were inherently linked using the examples of people making the ultimate sacrifice of taking their own lives as a consequence of not being able to cope with their burdens and suffering. Finally, the translator discussed some of the indigenous spiritual beliefs around causes and treatment for mental illness, providing greater detail about the traditional Sudanese healing approaches used for treating people with mental illness.

With regard to tribal language, the translator indicated that the northern notion of depression was best described locally as deep unhappiness, and that stress was equated with fear or suffering; and that an inability to cope with such unhappiness, fear or suffering was likely to cause ‘madness’. The following exchange between the researcher and translator describes these nuances of the Sudanese perceptions about mental illness:

[Researcher question: How does this community use the term depression? Is it considered an illness or a problem?] Yes it is a problem because of course, a person is just, can be with us, but in a few months or a few days, then accidentally he isolated or keep himself, not cooperating among the people. And then if there is occasions sometimes if he is invited he can refuse. So it is considered as a mental. So he’s not openly to the people. He’s not open. [Researcher question: So would you then call him “mad” or would you call him “depressed”?] Of course, there is no word for depressed with us…. Yeah, because depressed it become deeper than unhappy. [Researcher question: What about stress? Do people have a term for stress?] Yeah. Ah, stress we connect it sometimes with the fear. Yeah. [Researcher question: The fear of what?] Fear of anything. [Researcher question: So what would you call it if someone had many, many pressures in life? What would that be called here?] So it is connected with a suffering. Suffering. [Researcher question: OK. So stress and suffering are kind of similar?] Yeah, because we have a burden which is not can
carried out on it. A big problem which he cannot solve himself. So we call it a suffering. It is a suffering person. Yes, a burden. The burden is a problem but a person himself is we term it as a suffering person because there is a big burden on him.

In connection with the suffering described by the translator, this was further and once again, directly linked with individuals being unable to address their basic needs, or being unable to cope with managing their daily burdens for survival. In a discussion about local patterns of suicide, the translator conceded that many of those who were found taking their own lives were former Sudanese Peoples’ Liberation Army (SPLA) soldiers; however, he believed this was more linked to their inability to earn money to support their families. He believed suicide was also linked to a desperate lack of basic needs, given it was reasonably common for women to also suicide and there was no perceived difference between suicide amongst the host and returnee groups. The translator described the occurrences of suicide in the community as the ultimate example of how people were suffering, as follows:

Yeah, because sometimes somebody can put himself in the hut and then can lit the fire as a part of suicide….. There are different type of people. Some are young and some are... but the majority are middle age. It’s not likely to be elder. [Researcher question: And is it more likely to be men or women?] It is equal. Yeah. It is a certain cream used for hair, the black one. So it’s is called a sipka. It is used mostly by the ladies; they just stir it and put it in the cup and then drink it.... But the majority of the men, they are falling in the forest. Taking a big rope and go to the forest and then tie the rope around for his neck, then climb the tree, then releasing himself and so he is harming.... And also those who sit in their huts and burn the fire is the men also.... Yeah, soldiers are majority. And then the most, the second group is those who quarrel with their husbands, these are the ladies, they have a problem
in the family. Or it might be her husband left and she is alone and distributed sometimes by the problem of children..... So there is one almost four months back. One of the officers from our tribe, so he say that he struggle a lot and then he say that his name is not on the list for the salaries. So he just take off and go to the forest and hang himself.... But the mental is common because both of those who are in [host community] and those who came from outside [returnees]...

Throughout the participant interviews, reference to supporting people with mental illness through local magicians and witchdoctors was quite common and was linked to indigenous beliefs that mental illness was sometimes viewed as being linked with spiritual curses. The translator confirmed that magicians and witchdoctors in Sudan are discrete entities, with the magician usually consulted about the causes of illness, while the witchdoctors are attended to eradicate those causes and bring about healing for the suffering person. This distinction is described as follows:

*It’s a witchcraft is the person who do the practical things, like the killing a goat or something like that. But the magician man, just, there are certain things which he, he or she, it can be a women sometimes, she throw the things and then look at them and then say “Oh, the curse is from this causes”, so after they discover that they give the curse to the witchcraft to put the things in practically.*

Attendance to witchdoctors usually involves some form of sacrifice – a goat or cow, depending on the size or determination of the curse causing the illness. Also, the procedure conducted by the witchdoctor is usually dependent on the perceived size of the problem. However, regardless of these local indigenous beliefs, the translator additionally confirmed that local people had faith in the medical sector to assist them, and that sometimes, indigenous healers referred people back to the hospital for treatment when they believed this might be more effective for the person.
The current study did not delve deeply into the intricacies of the local and indigenous healing systems since this was not a primary area of research. Nonetheless, it is salient and essential to note that indigenous spiritual beliefs and their related healing procedures formed an important aspect of how people in South Sudan perceived mental illness and considered treatment options for these problems. The following excerpts provide a brief summary of what the translator described about the indigenous healing processes to help illustrate these local associations between mental health, mental illness and mental health treatment.

*So they might find out what is the causes exactly. So if it is a big curse, the witchcraft, witchdoctor might ask the cow, but if it less, after he discover it, it is where he might ask the goat or the hand sometimes…. You want to, to take the life or spoil the mind of that person. So slaughtering the goat it’s just to prevent, so that that magic can take the goat instead of the person.*  
[Researcher question: So the mental illness is considered like a curse?] *Yes…. Yes, they take the blood for the goat instead of the blood of the person…. Also there is hands [of the animal]. It is according to the size of the curse or the size of the magic they might discover…. And sometimes a part of it can be eaten and a part of it can be thrown in the river.*  
[Researcher question: Who eats it?] *Magicians people. It’s not allowed to be eaten by anybody….. So they take everything with them. Because they take it, and they took it from the body who is cursed.*  
[Researcher question: How often is that kind of thing done? Is it more common for people to go to the hospital or is it more common for people to go to the witchdoctor?] *Most people are, they go to the doctors in the hospital. And then if it doesn’t work sometimes they take a person to the village.*  
[Researcher question: Would a witchdoctor or a magician ever refer a person back to the health system?]
Yeah they refer it sometimes…. They do their things and their things don’t work
they may say that I complete my part, so the remaining part is belonging to a doctor.

6.6 Summary of the qualitative analysis

The qualitative research examined five key research questions, which explored the social structures of the sample, their concerns within their communities and the ways in which the Sudanese people culturally perceived issues of emotional and mental health. It also sought to understand how the participants from this South Sudan sample group viewed their present and future situations, associated their lack of basic needs and social systems with mental health and wellbeing, and whether or not this differed for the host and returnee groups. The following provides a high-level summary of the qualitative findings, which will be discussed in further detail in the proceeding Discussion chapters.

Analysis of the qualitative interview data revealed that the majority of the sample group ascribed to the traditions of the Shilluk tribe and kingdom, but commonly socialised with other tribes. When participants reflected upon those issues that most concerned them within their communities, they overwhelmingly established that their lack of basic needs and apprehensions about insecurity in their region were the most fundamental challenges in their lives. To a lesser extent, a number of individuals noted the increases of alcohol abuse in their community as concerning, while the returnees differed slightly from the host group by observing cultural shifts in the township, particularly in relation to a growing Arabic influence and emphasis on individual lifestyles. As participants contemplated how they and others in their communities felt about their present situation in South Sudan, a variety of responses emerged that reflected three main themes: (1) Feelings of despair where participants felt their situation was hopeless and an unhappy environment; (2) Feelings of optimism where some people harboured great hopes for what peace and development might bring to their lives; and (3) Feelings of needing greater leadership, particularly from the
government, where many participants believed they needed more from those in authority to lead them out of poverty.

Perspectives about mental health and mental illness were, for the most part, consistent across the host and returnee groups. Behavioural and speech changes were identified as the two most prominent indicators that a person in their community might be experiencing emotional or mental health problems, followed by individuals who did not engage socially with others. The lack of people following social norms and actively participating in ordinary social exchanges confirmed that social wellbeing was a key sign for people that others may be experiencing emotional or mental health problems. People with emotional or mental health problems were largely labelled as unstable, crazy or mad and sometimes believed to be potentially dangerous as well. The returnee group tended to describe individuals with emotional or mental health problems in a moderate way (e.g. unstable) but the host community members used stronger and more derogative language (e.g. mad or crazy).

Overall, a lack of basic needs was, according to the participants, the primary causing factor for mental illness. Social support was described as less of a concern for causes of mental illness by the participants, but it was fundamental in how individuals and communities sought treatment and care for those with mental illness. Social support, such as listening, individually caring for and encouraging people with mental illness was the most remarked upon way participants believed they would treat a mental disorder, closely followed by supporting people to get better access to their basic needs.

The translator believed that the host and returnee groups were not experiencing discord, and this was not suggested throughout the qualitative data from the participants. However, the returnee participants sometimes expressed a different type of ‘entitlement’ in comparison to their host participants, commenting on how little support there was for returnees, feeling more concerned about the cultural changes to the Southern Sudanese
lifestyles and influences and believing more strongly about the responsibilities of the government, including their responsibility to care for people with mental health problems. Though the returnee group could not be specifically identified as carrying greater stress, suffering or burden in comparison to the host group, the qualitative data has revealed some adjustment challenges for these Sudanese people. Yet, this was in contrast to the returnees who still reported that they believed they had greater autonomy in having control in their lives and capacity to apply problem solving approaches to managing the challenges in their lives. Thus, returnees and hosts appeared to differ in small but nuanced ways to the host community. Returnees saw greater cultural shifts in relation to the Arabic influences in their lives, and seemed more moderate in their attitudes towards people with emotional or mental health problems. This may be linked to returnees tending to place greater emphasis on the consequences of the war being a consequence for mental health problems, although they also believed the government was responsible for caring for people with such needs.

When considering the future in two years’ time, the host and returnee participants responded alike, with most believing their futures would be much the same or worse. However, when pushed to consider their futures in ten years’ time, while most acknowledged not knowing about the future, many participants felt this was distant enough to possibly dream of a better future, with lasting peace, less poverty and greater opportunity. Women expressed more pessimism about the future than men, feeling more dependent on external factors than internal factors, which was likely influenced by the finding that women expressed less feelings of autonomic control than men.

These results from the second study, along with those from the first study, are considered in more detail in the following Discussion chapter. The next chapter summarises the findings from the two studies, how the methodological challenges influenced these results.
and what the research findings suggest in relation to theoretical and practical implications and areas for further research.
CHAPTER 7: DISCUSSION

This thesis investigated mental health and wellbeing in South Sudan and explored how the migration experience might moderate these influences on mental health. The findings were related to some foundational psychological theories regarding the need for individuals to have access to their basic needs and social supports. This research was unique because it analysed these influences in the context of South Sudan where poverty, conflict and everyday struggles for meeting basic needs are prevalent. Furthermore, the study went beyond quantitative measures of mental health or illness and explored the qualitative perspectives of people from South Sudan. Specifically, it evaluated participants’ views about mental illness; how it is linked with their situational poverty; cultural beliefs about the causes, symptoms and treatment options for mental illness; as well as whether or not individuals felt they could control their lives and if their futures seemed hopeful in the short and long term. To achieve these aims, the research comprised two studies. The first study was a quantitative analysis of influences on mental health in South Sudan; the second qualitative study considered the subjective impressions of mental illness in South Sudan.

The ensuing sections of this discussion chapter provide an integrated summary of the two research studies in relation to the research questions and hypotheses. Following this, the methodological challenges faced in the research are highlighted. These were fundamental to the research process, set the parameters to the results and help explain the complexities of the findings. Next, the findings are considered for their theoretical implications, and this is followed by a reflection about some important considerations for the practice of mental health work in developing contexts like South Sudan. These practice implications are discussed in relation to research, psychological and humanitarian practice perspectives. The chapter reflects on the much-needed areas for further psychological research and practice
regarding mental health care and programs in low and middle income countries and some of
the tools that may need development to implement such work.

7.1 Summary of results in relation to research hypotheses and questions

The overarching aims of the current study were to better understand mental health and
wellbeing in South Sudan and to explore the similarities and differences between people who
remained in South Sudan throughout the civil war and those who had recently returned to
their homeland. After a preliminary exploratory analysis of the participants’ demographic
data, the first study quantitatively analysed the influences of basic needs and social support
on mental health and whether the migration experience of recent returnees might have
hindered or enhanced their mental health. In this instance, mental health was measured as a
continuum of symptoms on the Harvard Trauma Questionnaire (HTQ; Mollica et al., 2004)
and the Hopkins Symptom Checklist-25 (HSCL-25; Mollica et al.), which measured
posttraumatic stress, depression and anxiety symptoms. The second study used a qualitative
methodology of thematic analysis to explore what the participants perceived as the core
problems they faced in their communities and how they construed the notion of mental illness
and its causes, presentation and treatment. The second study also investigated whether the
participants had a sense of control over their lives and how they viewed their future.

7.1.1 Summary of the preliminary analysis from demographic data

Owing to the uniqueness of the sample group and the cultural context in which the
research was conducted, the preliminary exploratory analysis unearthed some interesting
additional findings. These findings alluded to the war having some influence on family unity,
participants’ access to education and employment, and some of the consequences of the
social roles of women.

There were indications that the civil war had influenced family and social structures.
This was suggested by more of the participants in the returnee group being separated from
their marital partners, and the practice of wife-inheritance being solely reported by the host group. Returnees also reported higher educational attainment than their host counterparts, suggesting that they had greater educational opportunities during their years of asylum than the host group who lacked access to education throughout wartime. Interestingly, however, even though higher education was linked to higher employment status, this did not translate to higher access to employment for the returnees. In contrast, and despite lower educational attainment, the host group participants reported greater steady employment than the returnees. This implies that the host group were more socially connected in their community to learn about and access employment opportunities. Aside from these group differences, the exploratory analysis did not reveal any other host-returnee group differences.

For the total sample group, higher education was found to be a protective factor for overall wellbeing for people in South Sudan. Additionally, lower education was linked with reduced access to health care. Although the data also revealed that any formal education, regardless of the level attained, was likely to contribute to improved wellbeing, its contribution to wellbeing was still not strong enough to translate to higher wellbeing amongst returnees who had significantly greater educational attainment than the host group. Age was another significant and moderate protective factor for wellbeing, with younger people in the sample group tending to experience more symptoms of acculturative stress, trauma, depression and anxiety than the older participants. However, aside from employment, education and age being identified as positive influences on wellbeing, the most important influence on wellbeing, as determined in the exploratory analysis, was gender.

There were marked gender differences on education and broad mental health. In this sample, women had significantly lower educational attainment than men as well as significantly lower outcomes on all the mental health measures. The effect sizes of these differences were substantial and variances in the mental health measures indicated that
regardless of education or employment status, being female was the most important predictor of poor mental health outcomes. This finding is likely linked to the gender roles of women in patriarchal Southern Sudanese society and is examined further in relation to the practice implications of this research.

7.1.2 Summary of quantitative analysis from Study 1 in relation to hypotheses

The hypothesis that higher access to basic needs, higher perceived social support and low acculturative stress would be associated with higher mental health outcomes was partially supported. Higher access to basic needs and low acculturative stress were significantly associated with higher mental health and wellbeing outcomes. However, perceived social support was not significantly correlated with the mental health and wellbeing measures. Consequently, the mediation hypothesis that social support would lead to greater access to basic needs was not supported.

It was further expected that greater access to basic needs would be the strongest predictor of higher mental health outcomes. The analyses revealed that low acculturative stress, after controlling for basic needs, was a stronger predictor to mental health; although basic needs were still a discrete and significant contributor to wellbeing, showing that people who had less access to basic needs tended to experience more symptoms of impairment, trauma, anxiety and depression.

The second hypothesis expected that the host group would be experiencing better mental health outcomes than their returnee counterparts, but this was not supported in the quantitative results of the first study. Similarly, the premise that host or returnee status would moderate the influences of basic needs, social support and acculturative stress on mental health was also unsupported. Simply put, the strength of the relationships between basic needs, social support and acculturative stress did not differ significantly across the two groups. Nonetheless, for the returnee group, the data revealed a moderate and significant
association with the length of time returnees had spent away from South Sudan and their mental health and wellbeing scores. The longer the time returnees had spent in asylum, the less symptoms they showed on the collective trauma, depression and anxiety measures.

7.1.3 Summary of qualitative analysis from Study 2 in relation to research questions

The first research question of the second study sought to ascertain how social order was determined for participants in their community. Nearly all participants reported belonging to the Shiluk tribe but engaging regularly with individuals from the many other tribes that resided in their Malakal, Upper Nile region. They conveyed that their familial rules were set by male family elders, unless in exceptional circumstances, a female head of household set the family rules when a male head of household could not be deferred to.

Family rules were distinguished from community rules, which were viewed as being set by either the Shilluk King, community leaders (e.g., chiefs or tribal elders) or the government.

The second research question related to whether or not participants perceived their situational poverty as a greater need than mental health concerns or their traumatic experiences from the war. It also sought to ascertain how people in South Sudan associated their access to basic needs and social support with mental health. The participants unequivocally confirmed that lack of basic needs and insecurity were their primary concerns. Their daily struggle to meet their personal and family needs for survival and the associated context of poverty was unquestionably a pervasive worry for the participants, as opposed to traumatic memories or experiences from the war, which barely rated a mention throughout the interviews. While insecurity was a prominent theme, participants relayed this concern as a desire for peace and communal safety that would allow them to more easily go about their daily tasks and feel a freedom of movement. Their concerns about insecurity were not so much a concern about the mental or emotional impacts of war but about how insecurity impacted their daily lives and access to basic needs. The key informant interview reiterated
Another community concern participants raised in their interviews was a notable increase in alcohol abuse in the community, particularly amongst youth. This could be a coping mechanism for people emotionally affected by war; however, the interviews suggested that this was more related to boredom or individuals attempting to cope with their poverty. For example: “... If they feel there is no job then they go looking for a group like them, those who are jobless, they collect themselves and of course where to drink. So they turn to drink”.

When considering community problems, the returnee group uniquely reflected on various cultural shifts and changes they were experiencing since returning to the homeland. They were concerned about increased Arab influences in the region and a greater focus on what they perceived to be individualistic lifestyles rather than traditional communal or tribal collectivism. The fact that only the returnees mentioned these cultural shifts was a salient feature of the data and suggests there are some adaptive challenges facing the returnee community. This was further supported in the key informant interview, with feedback that returnees tended to be more ‘enlightened’ than the host group, in that they had a greater appreciation for the benefits of living without war and consequently, they held higher aspirations for rebuilding their lives in the homeland following the peace agreements.

In relation to a lack of basic needs being perceived as the greatest problem facing participants, it could be seen that this also influenced their general sense of overall wellbeing – for better or for worse. Many participants expressed feelings of despair about their present situation, which translated to feelings of hopelessness and sadness. Their responses portrayed an impression that these participants were unable to visualise a life beyond simply seeking to survive. To a lesser extent, the peace process at the time of the interviews gave some
individuals a sense of optimism or opportunity, particularly if the newly formed government was able to lead the people toward an improved situation. Nonetheless, there was also evidence that the people were depending a great deal on the government to lead them out of poverty, and gradual realisation that this would not be instantaneous added to feelings of hopelessness (e.g., “They [the people] are hopeless. They are not happy. They are hoping the government will solve these problems and the government is not able…”).

The third research question honed in on what people in South Sudan perceived to be the causes, symptoms and treatment options for mental illness and how they as a community responded to those with mental illness. The causes of mental illness identified by the sample group reinforced the significance of people meeting their basic needs. Most people believed that poverty and a poor life situation were the most likely causes of mental illness, closely related to the notion that if people wished for too much or thought too deeply about desiring things beyond their reach, then this would also cause illness. Although some participants, predominantly returnees, reported their belief that the consequences of war were a possible cause of mental illness, this was usually unrelated to trauma experiences but the impact the war had on worsening poverty for the people and reduction of economic opportunities. There were also beliefs about poor physical health causing mental illness, particularly malaria, though this is not supported by medical research.

The importance of social interaction in this community was further highlighted and confirmed in this third research question. Socially unacceptable behaviours such as aggressiveness towards others, excessive alcohol consumption and poor or strange communication were all locally prescribed signs that individuals might be experiencing mental or emotional problems. Social withdrawal and isolation from others in the community was another prevailing theme to indicate that others might be mentally unwell, which further supported the idea that social engagement was a cultural norm and viewed as being crucial to
people’s wellbeing. This collectivist social support system was again affirmed when interviewees reflected that when people needed treatment for mental illness, it was usually a community responsibility to assist them and offer social support (such as offering advice), practical support (such as giving them food), religious support (such as prayer) and access to medical or traditional treatments. This was consistent with research by Ventevogel et al. (2013), who noted that people in South Sudan tended to seek social and emotional support from relatives, traditional healers and community members for depressive and anxiety-type syndromes rather than seeking help in the biomedical health-care system.

The overarching sentiment of the community towards people with mental illness was one of communal obligation to care and provide for them and show compassion, or commiseration, for their situation. The key informant interview also noted that social support in South Sudan was more likely derived from friendships than from families. However, despite social support being a predominant theme in response to people with mental illness, a lack of care and rejection of people with mental illness was also reported.

Many participants perceived people with mental illness as potentially dangerous or ‘bad’ and without social value. Consequently, some participants believed that people with mental illness should be cared for by the government (e.g., sent to jail), ignored or shackled. This also had some semblance to the Ventevogel et al (2013) findings that observed people in South Sudan view the dictomy of people with mental disorder as those with psychotic and non-psychotic symptoms as requiring very different approaches to support.

Returnees, compared with their host counterparts, were more inclined to view the government as being responsible for the care of people with emotional or mental health problems. Most participants felt that if they were unable to be assisted through traditional supports (e.g., social, practical, religious, magic, medical), then there was no hope for these individuals. The subsequent communal response was thus impassive and merely a fact of
A possible explanation for these attitudes may also be linked with the lack of local vocabulary for mental illness and the extreme perspectives of how mental illness presents. The participants mostly referred to others with mental illness as ‘crazy, mad or wild’ or ‘unstable or not of sound mind’, with host community participants more likely to harshly label and describe people with mental illness. They described people with mental illness as having a condition that was ‘all or nothing’ – either delusional or perhaps psychotic, or ‘normal’. Even though the researcher observed some of the participants presenting with emotional distress, anxiety, deep sadness or blunted affect, such mental states were not referred to by the participants when they considered the spectrum of mental illness; though as previously mentioned, some social withdrawal and isolation might be indicators of poor mental health. The key informant interview shed even more light on this, acknowledging that traditional Sudanese custom does not differentiate between thinking and feeling: “… the centre of feeling is the mind. Yeah. It is the mind who can think or feel like that”. Thus, in South Sudan, if a person was to share feelings of sadness or worry, others would perceive them as having a troubled mind, which would bring about further embarrassment or shame. Such perceptions and traditions may be what leads the community to perceive mental illness in a very ‘all or nothing’ way.

The fourth research question sought to determine if those interviewed felt they had a sense of control in their lives, and many reported feelings of autonomy in their lives, particularly if they were able to implement strategies to achieve this, such as prayer or problem solving. Some participants, especially women, felt they did not have control in their lives and were dependent on God, events or others (e.g., husbands), while others were uncertain if they had control, believing there were some things in their life they could control and other factors they could not. Returnees tended to report more feelings of autonomic
control than the host community, though this did not appear to influence their views of the future.

The fifth and final research question sought to understand how the participants viewed their short (2 years) and long term (10 years) future. Themes drawn from responses to this analysis suggested that people felt either hopeful about their future, or had a sense of uncertainty. The analysis further revealed that men and women perceived their situations differently, with women expressing the most uncertainty about the future and men reporting greater hopefulness. This was consistent for the short and long term future questions. Those who felt uncertain about the future reported that they were dependent on the peace prevailing, being able to continue meeting their basic needs, being supported by others (e.g., women supported by husbands), but essentially, they could not imagine if their lives would be improved or not. Very few participants believed their short term future would be comparable to their current situation and some expressed clear feelings of hopelessness or pessimism about the future, particularly if they were older participants who were unconvinced if they would survive the next 2-10 years. The key informant interview supported the notion that imagining the future was a difficult thing for people in South Sudan, because they were so accustomed to living in poverty and so absorbed by survival that to ‘dream about the future’ was impractical and unrealistic.

7.1.4 Integrated summary of key research findings

The 22 year civil war between north and South Sudan unquestionably influenced the lives of people living in and returning to South Sudan. This was demonstrated by changes to family and social structures, the higher educational attainment of returnee groups and evidence that people in the host community tended to be more socially connected and employed than their returnee counterparts. There were also indications that the Southern Sudanese culture was shifting to becoming more influenced by northern Arabic cultures and
independent lifestyles, though tribal and traditional governing mechanisms appeared to remain a strong feature of local custom. Individuals were also cognizant of the importance of the South Sudan peace process being central to their wellbeing and their ability to continue meeting their basic needs. As such, despite the war having contributed to the changing shape of Southern Sudanese life, the current research did not suggest that the war itself was the primary factor in relation to mental health and mental illness.

The research has clearly revealed that having access to basic needs and feelings of safety were the driving factors for mental health and wellbeing in South Sudan. This was verified in the quantitative data that showed people with higher access to basic needs were associated with high mental health and wellbeing outcomes and that returnees who had spent more time away from the conflict did better than those returnees who had shorter periods of asylum. Additionally, the qualitative data confirmed that lack of basic needs and local insecurity, which hindered access to basic needs, were the prevailing problems individuals identified in their community. Lack of basic needs and the daily struggle to survive led many participants to feel a sense of despair about their present situation and hopelessness about their future. Failing to meet basic needs was additionally linked to mental illness and its treatment, where participants believed poverty and lack of employment was a common cause of mental illness (including alcohol abuse), and as such, providing for basic needs was a practicable treatment. The key informant interview further established that people were so entrenched in working towards meeting their basic needs that being influenced by the traumatic experiences of the war were inconsequential. The influence of poverty was further evident in the qualitative data, where many participants expressed an inability to hope for good things in their future.

The qualitative data demonstrated that in South Sudan, a social support system and social order is likely to contribute to a range of wellbeing and protective mechanisms for
community members. One aspect of the social support system, confirmed in the key informant interview, was the importance of friendships for social support, which were viewed as safer and less inhibited than familial supports. Identification of individuals needing mental or emotional support is usually ascertained from their social engagement, behaviour and communication. Treatment, care and support for people with mental illness was also shown to be grounded by a community response that aimed to offer them social and practical support, in addition to assistance for accessing other possible treatments. However, this social support system could also be discriminatory and oppressive. Individuals are often discouraged to share difficult feelings with others and for some individuals with severe mental illness there was a likelihood of poor treatment and rejection from this social system.

The data also suggest that the traditional patriarchal social system was an encumbrance for women. The quantitative data revealed that women reported lower mental health outcomes on all measures of trauma, depression and anxiety symptoms than men; while the qualitative data showed that women had much greater feelings of dependence than personal control in their lives and were less hopeful in their views about the future.

They hypothesis that returnees might be experiencing poorer mental health than their host counterparts was not supported in the quantitative data. However, the qualitative data alluded to the suggestion that while the mental health of the returnees might not be significantly different to the host community, they may still be facing some challenges to their adjustment upon returning to South Sudan. This was evident from returnees noticing more cultural shifts in the social systems, a greater expectation of government leadership and a greater emphasis on how the war had influenced their lives, including their mental health. Returnees were more likely to consider the consequences of war (albeit as it related to their lack of basic needs) or trauma as causes of mental illness. The key informant interview
confirmed that returnees were equally affected by poverty as the host community, but that their expectations for an improved future were greater.

In addition to these findings about basic needs, social support and migration as they relate to mental health in South Sudan, the qualitative data further confirmed that mental illness was a socio-culturally derived construct. Despite some participants showing extremely high symptoms on the trauma, depression and anxiety measures and presenting throughout their interviews with a range of emotions, mental illness was perceived as being ‘all or nothing’ – be that entirely ‘crazy’ or not. There were no local words for concepts such as depression or anxiety, and the link between distress, sadness or worry was inherent with a link to a troubled mind, which brought with it the embarrassment and shame of mental illness. Therefore, even though the social support system provides some protective elements to individuals seeking comfort from friends or mental health care from within the community, mental illness in South Sudan largely remains an embarrassing concept, with mental health and mental illness presented as polar opposites rather than a spectrum wellness.

7.2 Methodological challenges of the research

Prior commentary about cross-cultural mental health research has widely recognised its inherent challenges, notably in relation to the reliability and validity of investigative measures, sampling methods, the construal of mental health and mental illness, indigenous vocabulary and the relevancy of the research variables (Bolton, 2001; de Jong, 2002; Inglby, 2005; Porter & Haslam, 2005; Summerfield, 2001; Thakker & Ward, 1998; van Ommeren et al., 2002). Inevitably, this study was subjected to similar methodological challenges. While it remains good practice to declare methodological problems and bias in data (Stiles, 1993), given the unique sample group that participated in this research, the methodological problems this study revealed clearly contributed to the interpretation of the findings, and have implications for practice and future research. Therefore, these methodological challenges are
addressed and discussed prior to an exploration of the theoretical implications of the research findings.

The first potential bias in the overall research was the use of World Vision South Sudan staff (community mobiliser and translator) and offices. This had benefits for the research; it enabled access to the participants and due to World Vision’s local base within the community it procured the trust of the people involved. It also allowed for some interviewees to be assisted with transport to and from the research site and use of the organisation’s offices ensured comfortable, private space for the interviews to be conducted. However, when humanitarian agencies consult with communities – be that for context analyses, research or the proposed implementation of programs – there is often an expectation from individuals that they will receive some type of practical assistance.

Based on community expectations of organisations such as World Vision, it is common for individuals to exaggerate their needs or to solely emphasise the needs for which they most desperately desire support. In the current research, this may have led to an over-emphasis on basic needs, or lack of basic needs, and participants potentially desiring World Vision to meet those needs at an individual way. In some ways, this was advantageous to the research process since information about participants’ needs formed an important aspect of the research. Participants were able to openly talk about the problems they were facing and asked to consider which issues facing their communities were most pressing. The researcher did not observe any causes for concern with regard to this connection with World Vision South Sudan, and due emphasis on basic needs from the participants was indeed reflective of the context. Also, participants were not observed to ask for specific needs to be met during their interviews, suggesting that they understood the notion of the research and that this was not an opportunity for individual aid assistance. Nonetheless, based on these factors, the data must be interpreted with these declared predispositions and possible biases in mind.
7.2.1 Sampling issues

Random sampling techniques were not possible in the quantitative study. Participants were recruited by convenience and snowballing approaches, although their demographic data suggested reasonable arbitrariness of host and returnee men and women from the Malakal township of Upper Nile, South Sudan. Notably, the sample group only consisted of individuals from the Shilluk tribe and from one urban township of South Sudan. Therefore, the findings of the research are only relevant to this tribe and may not be representative of the many other tribes or diverse rural regions of South Sudan, despite many commonalities across tribes. Furthermore, quantitative findings require inferential caution given the small sample size of the total group \((n=53)\), particularly where the statistical analyses further separated and compared data of host \((n=26)\) and returnee \((n=27)\) groups.

In contrast to the small sample size being a weakness of the quantitative component of the research, the total sample size was a strength of the second, qualitative study. Thematic analysis from the 53 participants enabled a saturation of common ideas and clear themes to emerge from the data. Also, the second study enabled a greater understanding of the general Sudanese cultural perceptions to be determined, since it is unlikely that beliefs about social order, community problems, mental illness and views of the future would be exclusive to the Shilluk tribe.

7.2.2 Quantitative measurement issues

The selection of quantitative measures for the first study was inherently limited by budget and time constraints for the data collection period. Therefore, a culturally-centred adaptation approach, including translations, pre-testing, acceptability and statistical analyses of the measures (Bernal & Saez-Santiago, 2006; Bolton, 2001) was not feasible. Inevitably this would have reduced some of the challenges to the psychometric properties of the measures used. Nonetheless, the measures were selected on a sound theoretical basis and
literature reviews; and though sometimes weak in psychometric attributes, the measures maintained adequacy and appropriateness for the purposes of this research.

Additional limitations and challenges in the first, quantitative study were the reliability and validity of measured variables; specifically the Basic Needs Total Scores measure, the Perceived Social Support Scales for Family and Friends (Prociando & Heller, 1983) and the Catwe Acculturative Stress Scale (Berry, Kim, Minde & Mok, 1987).

The Basic Needs Total Score measure was generated for this study, given that at the time of data collection, Basic Needs measures, such as the WHO (2011) Humanitarian Emergency Settings Perceived Needs Scale (HESPER) had not been developed. The Basic Needs Total Score measure comprised a composite score of basic needs and converted this to an ordinal scale. The scale could not be tested for test-re-test or inter-rater reliability and the variables, such as having access to water and steady employment, could not be logically linked even though they were theoretically derived. It is also noted that the inclusion of education on a wider scale (0-5) than other basic needs (e.g. water on a scale of 1-3) may have inadvertently impacted the weight of the overall total scores. Even though statistical analyses did not indicate this clearly, the utilisation of this measure remains a clear imperfection to the research methodology. Nonetheless, assumption tests using Spearman’s Rho correlations to confirm the theoretical premise of the measure (refer to Table 4, p.101) as well as Chi-square analyses to verify the analogous representativeness of the sample group (refer to Table 5), provided adequate rigor and validity for this measure to be used in hypothesis testing. Cooper, Lund and Kakuma (2012) acknowledged that poverty measures used in mental health research is a largely erroneous and unexplored issue. Therefore, the current study’s use of theoretical derivatives, contextual relevance of the items, the capturing of the multi-dimensionality of the measure, use of simple units of measurement and a clear explanation of how the basic needs measure was contrived is compliant with such
recommendations (Cooper et al.). Further to this, findings such as confirming basic needs as a unique contributor to wellbeing were also affirmed in the second study. These consistent results suggest that although warranting discretion, the Basic Needs Total Score measure was still meaningful in this research and its findings.

The Perceived Social Support Scales for Family and Friends (Procidano & Heller, 1983) was selected for use in the current research because it had previously demonstrated effectiveness in differentiating support from family and friends, in addition to being a parsimonious scale suitable for translation. However, the limitations of the scale in the current study were consistent with criticisms of prior cross-cultural research that indicated non-culturally specific measures used in research were often ineffective and problematic in their findings (Ingleby, 2005; Lewis-Fernandez & Kleinman, 1995; Summerfield, 1995, 1997, 2001; Thakker & Ward, 1998).

Analyses of the Perceived Social Support Scales for Family and Friends (Procidano & Heller, 1983) within this South Sudan sample group required many items, most notably reverse scored items, to be removed for the scale to achieve satisfactory internal reliability (Cronbach’s Alpha = .73 for the Family scale and .70 for the Friends scale). This process may have diluted the efficacy of the measure and possibly contributed to the lack of linear relationships found between social support and wellbeing. Another possible reason for this measure failing to determine social support relationships with wellbeing was its lack of face validity. It was confirmed during the key informant interview that some social support concepts, such as giving and receiving emotional support, did not resonate with the South Sudan culture or language.

Although the quantitative analysis, using the Perceived Social Support Scales for Family and Friends (Procidano & Heller, 1983) did not correlate with wellbeing, the qualitative data identified regular community social engagement as a social norm that
protected people from experiencing personal or practical problems. Social interaction with friends was perceived as being less inhibited than social interaction with family members, which was bound by formality and inter-family tradition. In contrast, social withdrawal and isolation was perceived as symptomatic of poor wellbeing and for individuals perceived to be dangerous to the community, they were more likely to be excluded from participating in the normal social exchanges. The qualitative analysis also demonstrated that social support, inclusive of practical support, was a feature of treatment for people with mental illness. Therefore, even though results in the first study failed to measure or demonstrate positive influences of social support and wellbeing, this was more likely a consequence of the failed scale (in this context) than an accurate depiction of social support playing no role in the wellbeing of people in South Sudan.

The Catwe Acculturative Stress Scale (Berry, Kim, Minde & Mok, 1987) was another scale restricted by limitations of the measure in this cross-cultural sample group. To the author’s knowledge, this scale had not been used in a developing context, where acculturative stress was hypothesised amongst a returning group as opposed to an immigrant group to a developed context, where the scale had been usually implemented (Berry et al, 1987; Neto, 1994). However, because the scale had been previously used in translated versions, showed good reliability and face-validity and was dichotomous, the scale was deemed suitable for testing acculturative stress in the current research.

Initial reliability analyses of the Catwe Acculturative Stress Scale (Berry, Kim, Minde & Mok, 1987) were strong in this South Sudan sample group (Cronbach’s Alpha = .84). However, further testing revealed that the construct of acculturative stress, as measured by this scale, did not discriminate from the measures of traumatic stress, depression and anxiety. The acculturative stress subscales were positively and strongly correlated with all of the subscales of the Harvard Trauma Questionnaire (HTQ) and Hopkins Symptoms Checklist-25
most notably with the HSCL-25 Anxiety Subscale ($r=.74$, $p<.01$). The fact that there was no significant difference between the host and returnee groups on the acculturative stress measure further corroborated this theory. Furthermore, the finding that acculturative stress was more strongly correlated with mental health and wellbeing than basic needs could be attributed to this poor discriminant validity; and likely suggests that if acculturative stress had been removed as a potential predictor of wellbeing in the statistical models of the first study, basic needs (which still showed a discrete and significant contribution to mental health and wellbeing) would have been more likely to be the strongest predictor of mental health and wellbeing in South Sudan, as hypothesised. This notion was supported in the qualitative analyses, which clearly showed lack of basic needs as the predominant community problems identified by the participants.

Interestingly, the Harvard Trauma Questionnaire (HTQ) and Hopkins Symptoms Checklist-25 (HSCL-25; Mollica, McDonald, Massagli & Silove, 2004) showed the strongest internal reliability in this sample and proved to be effective measures of traumatic stress, depression and anxiety. Undoubtedly this is the consequence of these measures now having wide utility and validation across many cultures, including Africa.

Alongside the above-mentioned challenges created by the use of the non-validated measures for social support and acculturative stress, the research clearly exposed the importance of psychological research measurement instruments being culturally relevant, flexible for translation and thoroughly examined before being rolled out to new research initiatives. While the author acknowledges that this was understood in the process of the present research design, there remained time and financial constraints, which meant non-validated measures were included in the absence of such measures with cross-cultural (and Sudanese) validity being available. This is an obstacle common to clinicians, humanitarian organisations, governments and other cross-cultural mental health researchers working under
the pressure of attempting to reduce the significant mental health treatment gap in developing
countries. It is evident that much work remains in the future for developing measurement
tools with greater plasticity that enable inter-cultural and language adaptations. Based on
findings from this study that social support was important to wellbeing and mental health in
South Sudan, but could not be quantitatively measured, it appears that social support
measures may be a particularly important construct for greater cross-cultural investigation in
the future.

The methodological challenges of finding and using psychological measures for
constructs, such as social support and acculturative stress, further suggests that non-validated
measures have potential to generate more problems than benefits in the interpretation and
generalisability of the findings. Therefore, a qualitative component to any mental health
research in cross-cultural contexts remains essential. As the following sections will describe,
qualitative research is not without its own challenges, but its depth and penetration to
understanding local perceptions about mental health and mental illness cannot be
underestimated.

7.2.3 Qualitative methodological challenges

The current research relied heavily on qualitative data to complement the quantitative
findings as well as to examine the unique cultural perspectives about mental health and
mental illness in the Southern Sudanese sample. However, some factors in the methodology
may also have influenced the results.

The participant’s perceptions were analysed based on the transcripts of the translator’s
interpretations of local language to English language. Due to English being a second
language for the translator, some of the translations were paraphrased or summarised. This
was especially the case, as confirmed in the key informant interview with the translator,
where some local concepts did not have specific English vocabulary equivalents; and
similarly, where some of the English words and concepts, such as depression or emotional support, did not have equivalent local terms. Though this added a complexity to the qualitative methodology, it was not prohibitive to ascertaining the key ideas that participants were portraying in their interviews.

Another important consideration for the qualitative data was that the translator was male, and a well-known local church elder acquainted with some participants. It is possible that participants familiar with the translator may have been more reserved in sharing their feelings or opinions or perhaps more impassioned about certain topics. Women participants might have also felt uneasy about sharing concerns in their life in the presence of man. On the other hand, men participants may have felt influenced in what they shared throughout the interviews given they were in the presence of a western white woman. Overall, the qualitative data needs to be interpreted cautiously with these possible biases in mind. Nevertheless, the researcher who was present throughout every interview did not perceive this familiarity between some participants and the translator or the influence of a western woman to be problematic in any way, and it was not expected to impact the accuracy of information received during interviews. It was noted that some participants greeted the translator in a more friendly and familiar manner than others, but this did not appear to influence the content of the material they shared, or the translator’s interpretations of what they were saying. Also, as the translator used soothing tones of voice and an empathic stance with participants, particularly women, there were no obvious indications that the male translator was problematic.

The nature of the preconceived semi-structured interview format may have been prohibitive to exploring the expanse of local mental health and mental illness perspectives. For example, one participant and the key informant interview made reference to suicidal behaviour in the community but this could not be further explored because of the limitations
of the semi-structured interview format, which aimed to look at specific themes. Had a purely phenomenological or less structured approach to the qualitative methods been used, there would have been greater flexibility to more thoroughly explore these types of issues (Smith & Osborne, 2008). Therefore, while the qualitative data analysis provided the research with important local themes and perceptions about mental health and mental illness, it should not be interpreted as entirely comprehensive of this culture. No doubt, further work could be done in South Sudan to delve more specifically into aspects of mental illness.

Regardless of the qualitative and quantitative analyses facing a range of methodological challenges, this mixed methods research design proceeded to identify some important findings about the influences of mental health in South Sudan, which quantitative and/or qualitative analyses could not uncover singularly. For example, the influence of social support could not be empirically verified in the first study, but the qualitative data in the second study showed how communal social engagement was vital to caring and protecting individuals, including those with mental illness. Another example is that despite acculturative stress not functioning as a discrete variable in the statistical research models, the suggestion that returnees might be experiencing adjustment challenges was observed from the subjective qualitative study. Lastly, basic needs was overwhelmingly emphasised in both the objective and the subjective data. It clearly determined that the primary driver of wellbeing in South Sudan was being able to meet daily needs, which is supportive of theoretical frameworks about mental health and wellbeing.
7.3 Theoretical implications of the findings

The findings of the current study are consistent with various theoretical frameworks, such as Maslow’s (1954) theory of human behaviour and motivation, the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007) and Miller and Rasmussen’s (2010) model of daily stressors mediating the relationship between war exposure and mental health. Nevertheless, many of the findings can also be explained by the actual South Sudan context in which this study was based. The following sections consider the theoretical implications of the research findings, but begin with a discussion of how the findings relate specifically to South Sudan, its culture, environment and history, which is essential to forming the foundation of any cross-cultural research outcomes (Thakker & Ward, 1998).

7.3.1 South Sudan’s context

According to history, literature, United Nations (UN), International Non-Government Organisations (iNGOs) and other objective measures of poverty, such as the Human Development Report/Index (HDI, 2010), the introductory context analysis about South Sudan (refer to Chapter 1.6) referenced the many indicators of the nation’s poverty and conflict-ridden landscape. Indicators such as persistent insecurity from large scale and tribal conflicts, low education rates, shortened life-expectancy, difficulty accessing health care and extremely low annual incomes all suggest that people in South Sudan have suffered under oppressive and extreme poverty conditions (Sachs, 2005). This was verified in the current research.

Mading Deng (2003) highlighted that objective poverty, such as conditions already described, can often differ from subjective poverty; but this was not suggested in the current research. The participants overwhelming perceived themselves to be living in very difficult and poor circumstances and identified their lack of basic needs as their foremost concern.
The challenge to meet survival needs also permeated their views of the future and feelings of having control. For instance, many participants identified that the future was uncertain simply because they could not imagine life beyond poverty, and they were unable to control their life situation because they depended on factors beyond their influence, such as national peace and increased employment opportunities.

Future mental health research may be able to override objective and subjective perceptions of poverty by controlling experimental conditions or focusing solely on psychological symptoms. However findings in this study indicate that such approaches may separate a fundamental element that directly links to the mental health and wellbeing of people living in contexts such as South Sudan. In this study, the peoples’ lack of basic needs was a powerful influence on what preoccupied the thoughts of participants, what concerned them and how they shaped their beliefs about mental health and mental illness. It also influenced their views of the future and formed part of their cultural practices (e.g., providing practical support to others).

Also confirmed in the findings were the depiction of the Sudanese being strongly assimilated to their traditional and tribal social structures, many of which were previously documented by Seligman (1911), Kemp and Rasbridge (2004) and more recent assessments from the UN. Specifically, the patriarchal nature of the Sudanese culture was evident along with the status of women being dependent on male elders. The present findings also indicate that life in South Sudan was particularly difficult for women, where they reported significantly lower mental health and wellbeing outcomes in comparison with men. Interestingly, despite the autonomous South Sudan government being formed during the Comprehensive Peace Agreement (2005), and in some instances seen to be the nation-leaders, participants continued to pay homage to and seek social order from the long-standing Shilluk King and monarchy.
Since the time of data collection for the current research (completed in January 2008), the context for The Republic of South Sudan has changed considerably. The nation is now completely independent of north Sudan, but a war has ensued and persisted up to the time of the research publication (refer to http://reliefweb.int/country/ssd for real-time updates on The Republic of South Sudan). Due to this heightened insecurity, it is possible that if participants were asked the same questions now as they were in 2008, they may well have cited insecurity as being their primary concern. Nonetheless, the stress of meeting their basic needs would be likely linked to this concern. The current findings indicate that insecurity and the emotional impacts of war were a stressor for participants, but not so much due to the trauma or emotional distress the war caused; rather, they were concerned about insecurity influencing their basic safety and ability to access their basic needs. The previous civil war (from 1983-2005) was also shown in this study to adversely affect family and community social structures, such as the family separations apparent amongst returnee communities and differences in traditional wife-inheritance customs. Therefore, despite the current insecurities in South Sudan and the temptation to be solely drawn into the trauma and mental scars of war, that the lack of basic needs emerged as a primary driver for mental health and wellbeing remains relevant to any work that is planned in response to the current situation in South Sudan. This, along with the findings that social connections and structure appeared to play an important role for people, is all supportive of theories about wellbeing (e.g., IASC, 2007; Maslow, 1954). This is further reflected in the following sections.

7.3.2 Basic needs, safety and social inclusion for mental health and wellbeing

In both the quantitative and qualitative studies of the research, basic needs, safety and social inclusion were reported as a critical links to mental health and wellbeing. Participants reported their lack of basic needs and insecurity as the foremost problems facing their community. They further identified that a poor ‘life situation’ – poverty, hunger, lack of
property and stress - were the main causes of emotional or mental health problems. This was confirmed in the quantitative study showing people will less access to basic needs experienced significantly higher symptoms of traumatic stress, depression and anxiety.

That basic needs positively influenced wellbeing is consistent with Maslow’s (1954) theory of human behaviour and motivation. Maslow suggested that individuals were motivated, first and foremost, to meeting their biological and physiological needs followed by their safety needs, or so-called deficiency needs, before they focused on interpersonal growth needs, such as building personal esteem or working towards ultimate peak experiences and self-actualisation. As participants in the current research showed, they were fixated by their poverty context and desired safety and national peace; as a consequence of this preoccupation, they were often unable to feel in control of their lives or a sense of hopefulness about the future.

Belongingness and love needs are also considered important deficiency needs (Maslow (1954). For the research participants, social support was seen as an important aspect of community life. They easily viewed themselves along tribal affiliations and acknowledged that when individuals became socially isolated or behaved and communicated in culturally abnormal ways, this was demonstrative of a person likely to be experiencing emotional or mental health problems. Further, they viewed social and practical support for others with emotional or mental health problems as the main course for providing them assistance and treatment. Many participants felt a sense of commiseration or responsibility towards those in need and believed it was the communal and familial social structures that needed to respond to such needs. In contrast, for the individuals who could not be supported and persisted in behaving in socially unacceptable ways (deliberately or not), they were rejected and shunned from the social structures. This social consequence of mental illness is consistent with World Health Organization’s (2010) position that individuals with mental
illness are more likely to experience discrimination and lack of opportunity to engage in community life.

The present data are also aligned with the recommendations for humanitarian responses to the mental health needs of people affected by crises as per the *Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007). The assumption of these guidelines is that people affected by crisis situations, such as the conflict and insecurity observed in South Sudan, are unlikely to have the capacity to work through intensive emotional or traumatic experiences, such as typical psychotherapeutic processes, if their basic services and security, or community and family supports remain unmet. The guidelines posit that following crises, the majority of people will return to normal psychological and mental states once these fundamentals of basic needs and social supports are restored.

Although there have been concerns that the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007) are solely based on a consensus and evidence-informed approaches (Wessells & van Ommeren, 2008), the current finding that lack of basic needs is directly linked to lower mental health and wellbeing outcomes, without reference to specific traumatic events from war, provides some empirical substantiation for their premise. The findings also add credibility to Miller and Rasmussen’s (2010) mental health model that suggests daily stressors, including those induced by conflict and ordinary daily stressors related to poverty, may be mediating the direct relationship between war exposure and mental health. Thus, based on the current research findings, the premise of the IASC Guidelines and Miller and Rasmussen’s mediation model of mental health in conflict settings, Bolton and Betancourt’s (2004) recommendations that mental health programs begin with identification of needs, and where possible, provision of those needs before trauma-focused or intensive therapy interventions are implemented.
7.3.3 Understanding the construct of social support in South Sudan

Based on the emphasis of social support by Maslow (1954), the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007) and the idea that in the developing context of South Sudan, social support was possibly linked to the notion of social capital (Burt, 1997; Pennar, 1997), the construct of social support was a key variable in the current research, which attempted to ascertain the influence of social support on mental health and wellbeing. However, the findings about this influence of social support in South Sudan were mixed. It is therefore important to unpack this further in light of the theoretical explanations about the role of social support as a potential protective or curative factor, and how this might be relevant or different in the South Sudan context.

As outlined under methodological challenges (Chapter 7.2), the current research was unable to measure the participants’ perceived social support from family or friends. That the Procidano and Heller (1998) measure was ineffective in the research is the first indication that the construct of social support may be represented differently in this region of South Sudan. Specifically, data from the measure suggested that the participants did not tend to view social support as an emotive or cognitive experience. This is in light of many items in the scale that related to ‘emotional support’ or the sharing of opinions showed the poorest internal reliability. This suggests that the difference between real and perceived social support (Barrera, 1986; Hobfoll, 1998) may not be as relevant to this group, who tended to focus more on the elements of practical support, particularly when others were in need, as the community responses to supporting people with mental illness was shown in the second, qualitative study. As such, the function of social support in this community could be better explained by Cohen and Hoberman’s (1983) theory of a ‘buffering hypothesis’ – where people feel more supported by others during high-stress periods – rather than a ‘main effects hypothesis’, where the function of social support is perceived to be a protective factor all of
the time. Following on from this possible explanation of how social support may be functioning in South Sudan culture, the four categories of social support conceived by House (1981) may be a more relevant model for this community.

The four categories of social support proposed by House (1981) were (1) emotional support; (2) appraisal support; (3) informational support; and (4) instrumental support. Based on the qualitative analyses, the participants noted social affiliations with their tribes and this tended to contribute to men and women understanding their gender roles and the functions of social order and structure. Nonetheless, the participants and the key informant placed minimal emphasis on emotional support, particularly from within the family or on appraisal support. In a variety of ways, however, they highlighted the notion of social support as it related to informational support, such as offering advice to others and attempting to help others solve problems, and on instrumental support. These approaches to giving and receiving support were most notable when the participants explored their personal and communal responses to supporting people with emotional or mental health difficulties. In many respects, these findings further intimated that in South Sudan, social support may also be an asset, or capital, such as the theories of social capital that are now beginning to be more thoroughly researched (Pennar, 1997; Lochner, Kawachi & Kennedy, 1999).

The concept of social capital playing a key role in this community might also help to explain why the host community reported having more steady employment than their returnee counterparts, despite the returnees’ higher educational attainment. In accordance with Pennar’s (1997) definition of social capital, relationships can also influencing economic growth. Working on the assumption that the host community, by remaining in their homeland throughout the civil war, experienced less disruption to their social networks in comparison to the returnees, it is likely they are more socially connected to potential employers and have an established social network that with offer them information about
potential employment opportunities. In contrast, as part of the migration process of the returnees and their extensive years in asylum, they will have experienced deterioration in their social networks. Based on social capital theory, the returnees would therefore have less economic opportunities.

In summary, the current study was unable to measure social support as a discrete variable. Notwithstanding, the qualitative analyses demonstrate that social structure, tribal affiliation, informational and instrumental support were important aspects of community life, particularly in relation to helping individuals access their basic needs (such as employment) and assisting others with mental illness. What remains to be determined, however, is the actual way or process of how social support contributed to the wellbeing of participants and as a potential protector of mental health (such as previously determined in western studies; Barrera & Ainlay, 1983; Hobfoll et al., 2007). It is evident that this is an important area for more research, and this is discussed in later sections.

7.3.4 The returnee experience

The introductory sections of this research outlined the experiences of asylum seekers, refugees and internally displaced persons (see Chapter 2.3), which commonly involve traumatic events (van der Veer, 1998) and extensive periods of time away from their homelands (UNHCR, 2007). Consistent with these reports, the returnee group of the current research had also endured long periods of time living in asylum ($M=17.4$ years, $SD=3.51$ years) and were showing some indications that living back in the homeland was an adjustment. This was evident by their descriptive data which showed they were struggling to find local employment, and the evidence that the longer they had spent living in asylum the more likely they were to suffer with symptoms of traumatic stress, depression and anxiety. The qualitative analyses suggested also that the returnee group had slightly different expectations of their homeland and perceived problems in their communities somewhat
differently to the host group. Despite these identified differences, the returnee group still showed less symptoms of mental illness than the host group; a finding consistent with prior research (Porter & Haslam, 2005).

In a meta-analysis of mental health amongst displaced populations, Porter and Haslam (2005) hypothesised that repatriated groups would experience poorer mental health outcomes, based on the adverse experiences of displacement and acculturative experiences. However, their study revealed that non-refugee groups, which in this study would have been equivalent to the host group, showed higher prevalence of mental illness, followed by returnees and then by groups that continued to live in asylum; and that this finding might be explained by the host groups having greater proximity to direct conflict experiences. The present study supported the host group experiencing worse mental health outcomes than the returnees. This could be explained by many factors also evident in the current data. For example, the returnees, despite having less employment, still have better access to and quality basic needs (e.g., better housing), higher education and perhaps a greater sense of agency given their prior capacity to escape the conflict and make individual decisions to return to their homelands – decisions the host community appeared to have less agency to utilise. Also supporting this idea is the finding that the returnees who had spent longer time in asylum and were more likely to experience symptoms of mental illness, could be a consequence of their struggle to readapt to personally being responsible for meeting their basic needs, and the reduced agency that was a consequence of living in such poverty conditions of the homeland.

During the period of the Comprehensive Peace Agreement (2005), Southern Sudanese internally displaced people who were living in reasonably organised camps in Khartoum throughout the conflict (where the majority of the returnees in the present study had returned from), were provided some regular access to basic needs from humanitarian organisations. Supplies such as shelter, food, water and health care were made available to the displaced
population, albeit in very rudimentary ways. Therefore, returnees in this present research
may have begun to feel dependent on others for assistance to deliver their needs, which might
also account for returnees tending to place more expectations of the newly formed
Government of South Sudan for addressing poverty in their communities. Theoretically,
once the displaced returnee group had migrated back to their homeland, they may have found
that being individually responsible for meeting their own needs somewhat stressful and
resulted in lower mental health outcomes (in comparison to other returnees who had not been
displaced for long periods of time). However, it is unclear whether this challenge to
adjusting to life back in the homeland could be considered an ‘acculturative stress’ as defined
by Berry’s (1987) acculturation model.

In the previous section on social support, it was proposed that that the returnee group
may have experienced a disrupted social support system, which may explain their lack of
access to employment opportunities. Based on Berry’s (1987) model of acculturation (see
Chapter 2.4), this could be the consequence of the returnee group being excluded by the host
group, or of a failure of the returnee group to integrate effectively with the slightly altered
social structures of the dominant society. The returnee group noticing cultural shifts and
changes to Southern Sudanese lifestyles in the qualitative data might also point to challenges
of integration to the changed cultural environment of the homeland. Alternatively, that
returnees who had been away longer experienced higher symptoms of mental illness could
reflect feelings of being socially or mentally separated from the host group and marginalised.
This would further support research showing that migrants experiencing separation and/or
marginalisation are prone to social seclusion, isolation and mental illness (Al-Issa &
Tousignant, 1997; Berry, 1992, 1997; Berry, Phinney, Sam & Veddoer, 2006). Overall, there
was no consistent pattern of findings in the current research to definitively indicate the
returnee groups experiencing acculturative challenges as Berry’s model has described.
In summary, based on the minimal data available from the current research, it cannot be conclusively ascertained if acculturation challenges were underlying in the differences found between the returnee and host groups. Nonetheless, the data show that the migration experience had, in some ways, influenced the returnees’ access to basic needs, social supports and mental health and wellbeing. The qualitative analyses further reveal that the perceptions of returnees about their immediate environment differed slightly from the host group. Returnees were more cognisant of cultural changes amongst their Southern Sudanese communities, held higher expectations of the newly formed government and were more inclined to focus on the consequences of war as causal factors for their poverty and for mental illness.

7.3.5 Southern Sudanese perceptions of mental health

The broad goal of the DSM-IV-TR (APA, 2000) is to offer a common language and standardised criteria for the classification of mental disorders that allows clinicians and researchers to diagnose, communicate about, study and treat people with mental health problems. However, consistent with many theorists and critics of the DSM-IV-TR (Jones & Craddock, 1997; Kleinman, 1977; Kleinman & Cohen, 1997; Thakker & Ward, 1998; Verhulst & Tucker, 1995), the current research clearly identified that the social and etiological factors associated with culturally-derived perceptions of mental illness were more akin to a biopsychosocial view of mental health than the DSM’s biomedical taxonomy. This follows the original WHO (1948) definition of mental health (see p.25), and Engel’s (1977) longstanding conviction that the combination of physiological, psychological and social factors of peoples’ lives contribute to their overall mental health and wellbeing.

In the current research, participants connected physiological needs to wellbeing. They expressed their concerns about basic needs and believed that lack of basic needs and being preoccupied with an improved life situation were causes of mental illness. They
recognised that physical health problems might also be linked to mental illness and that material poverty was a factor for being unable to depict future life circumstances. The social connections for people in this sample group were pertinent to identifying individuals with emotional or mental health problems as well as ensuring they had access to care and treatment, such as via social support, practical support and assistance to traditional treatments. The key informant interview further confirmed that peoples’ persistent worry about their life situations pervaded their thinking about the present and the future. As such, the combination of causes, treatments and presentations of mental illness showed how a biopsychosocial approach was valid in this culture. Although a pure biomedical approach might have yielded positive diagnoses amongst participants or others the community, this may not have informed best treatment options, such as traditional healing or religious practices, or enlisted a an approach to strengthening communal and social supports. Such approaches to community care for people with mental illness is consistent with existing research from Africa, where traditional healing mechanisms have been deemed vital to the treatment and care of people with mental illness (Mbatia, Shah & Jenkins, 2009; Vontress, 1999).

7.3.6 Southern Sudanese perceptions of mental health – a dichotomous or dimensional perspective?

One of the challenges in the current research was how to ascertain the broad construct of mental health. In a biomedical perspective of mental illness, such as the taxonomy of the DSM-IV-TR (APA, 2000), the two constructs of mental health and mental illness could be viewed as dichotomies. However, to avoid undermining cultural perceptions of mental health and mental illness (Kleinman, 1977; Thakker & Ward, 1998), and to allow for the notion of mental health being a continuum, the dimensional approach was utilised in the current research by measuring numbers of symptoms on the Harvard Trauma Questionnaire and
Hopkins Symptom Checklist (Mollica et al., 2004), where higher symptoms were indicative of lower health and greater illness. The quantitative analyses was successful using this approach, with a range of findings indicating that some participants were more adversely affected by the common symptoms of traumatic stress, depression and anxiety than others (e.g., returnees who had been living in asylum longer, women and younger people). However, the qualitative analyses suggested that both a dichotomous and continuous perceptions of mental health was prevalent in this sample group.

When participants were asked about the signs and symptoms of people who might be experiencing mental illness, quite severe presentations were reported, such as people walking naked in the street or behaving in very inappropriate ways. When asked what names were given for mental illnesses in South Sudan, most participants offered an ‘all or nothing’ label – people were either ‘crazy, mad or wild/bad, dangerous or without value’ or they were normal or sane. This suggests that people in South Sudan perceive mental illness as a sane/insane dichotomy and pay little credence to the notion that some people might be experiencing mental illness, even though it may not be defined as ‘severe mental illness’. For instance, participants implied that when individuals withdrew socially or did not engage in normal communication with their family or friends, or even that people engaged in hazardous alcohol use, they did not necessarily attribute these ideas as mental illness. Another example was that some participants presented in the research interviews with presentations of deep sadness, despair and distress, yet they did not believe themselves to be unwell or ‘crazy’. The qualitative data suggested therefore that people in South Sudan appear to experience mental illness as a spectrum of symptoms and presentations, but local perceptions do not attribute mental illness until individuals begin presenting on the more severe end of that continuum.

Another important implication of this finding about the perceived dichotomy of the mentally well and mentally ill in South Sudan would be how a diagnosis from the DSM-IV-
TR (APA, 2000) might be perceived locally. The analyses showed that while the majority of the participants believed it was a community responsibility to be empathic, supportive and caring towards people with mental illness, a large proportion also indicated an impassiveness and prejudice towards people with such conditions. The data reveal that people with mental illness were often exposed to a range of human rights violations, such as being imprisoned, shackled or excluded from community life. Therefore, even though a range of less ‘severe’ mental illnesses appear to be impacting people in South Sudan such as traumatic stress, anxiety, depression or alcohol abuse, the labelling and diagnoses of such disorders may bring with it social stigma and risks of poor treatment or rejection from vital social structures that enable all people access to emotional and practical assistance. Although the DSM-IV-TR Cultural Formulation asks the question: “how does your community react if somebody has serious emotional or mental health problems?” the finding that there may be specific vulnerabilities and risks to individuals with mental disorder from different cultures is perhaps a shortcoming of the cultural formulation, which does not specifically address this concern.

7.3.7 Psychopathology and the DSM-IV-TR Cultural Formulation (APA, 2000)

The current research did not aim to ascertain psychopathology in the sample group. However, the qualitative data implied that some people in South Sudan were experiencing a range of symptoms that could be linked to psychopathology. For instance, references to ‘crazy people’ talking to themselves or behaving erratically was suggestive of psychoses, and the sadness that some participants showed in their presentation during the research interviews, such as blunted or acute affect or general distress pointed towards possible depression. There were references to growing alcohol abuse as a consequence of boredom or as a coping mechanism. As well, some participants scored quite high on the Harvard Trauma Questionnaire and Hopkins Symptom Checklist that might have been indicative of mental disorder had a diagnostic cut-off score been determined. Therefore, while participants clearly
identified that meeting their basic needs was their primary concern, mental health needs in
South Sudan still warrant attention. Nonetheless, as already discussed, this can only be
achieved through a culturally relevant approach that incorporates local beliefs, causes,
presentations and treatment options. The use of the DSM-IV-TR (APA, 2000) cultural
formulation provided some guidance to supporting this process.

The application of the DSM-IV-TR (APA, 2000) Cultural Formulation was helpful as
a research tool in the second study. It is acknowledged that this tool is intended as a
diagnostic and treatment guide, but it nevertheless provided an effective starting point for
exploring the issues related to mental health in South Sudan. Specifically, the cultural
formulation supported a clear description of how the participants perceived their social
identity, what they believed caused mental illness and what were the culturally appropriate
treatment options. It also supported a greater understanding of how this Sudanese community
responded to mental health concerns and their attitudes towards people with mental illness.
However, on its own, the cultural formulation was not comprehensive. It did not identify
potential risks or vulnerabilities for people with mental illness or what might be the social
consequences of being diagnosed with mental illness. The questions were also very specific,
and did not allow a broader exploration of community issues, such as those obtained from
ethnographic methodologies such as exploratory questions used by Bolton and Tang (2002).
Thus, while the cultural formulation yielded benefits for the research in this cross-cultural
sample, it needed supplementary inputs to enable the study to grasp broader issues facing
individuals and their community.

7.3.8 Perceptions of control and views of the future

Specific psychological theories about autonomy, feelings of control (such as Deci &
Ryan, 2000) or hopefulness about the future (Marshall & Arvay, 1999) were not explored in
this research. Rather, the research considered feelings of control and views of the future as a
broad projection of wellbeing, given its links to human rights (refer to Universal Declaration of Human Rights, 1948), quality of life (WHO, 2001) and mental health (Keyes, 2005; MacLeod & Conway, 2007; Snyder, 2002; Wichmann, 2011).

Participants’ views of their perceived levels of control in their lives further emphasised the importance of the sociocultural traditions in South Sudan. Although many participants reported that they believed they had some degree of autonomy in their lives, they also reported that this was because they drew upon traditional coping strategies, such as religious practice and prayer, practical problem solving techniques or drawing on past experiences of endurance in order to face new challenges. Being resourceful and making the most of opportunities peace was bringing to the communities also translated to feelings of greater freedom of movement and new education or work opportunities. For these participants, they were able to view their future with hopefulness and optimism.

In contrast, but still reflecting the Sudanese social structures and culture, many women reported feelings of dependence on others, such as male heads of household or God, as having control in their lives. Consequently, the data showed very few women as perceiving the future hopefully; rather, they tended to perceive their future as either unknown or with a sense of pessimism. Sapolsky (cited by Miller & Rasmussen, 2010) has suggested that feelings of having minimal or no control over difficult life circumstances commonly lead to a perception of events or daily pressures as being stressful. In the current research, specifically for women who bear the greatest burden for meeting basic needs, Sapolsky’s theory may explain why many participants viewed their future with a sense of uncertainty or pessimism. For example, if a woman felt that she had no control over her daily struggles and life situation, this leads her to feelings of stress or foreboding, and it is difficult for her to perceive the future with any sense of confidence.
Overall, the current research identified mixed perceptions about feelings of control and views of the future. The sample group was divided between feeling autonomy and dependence in relation to having control over their lives, and with regard to their perceptions about the future, the group was again split between those who believed that peace brought them a sense of hopefulness, but others who dared not think about future because they were preoccupied with more immediate and pressing concerns; mainly meeting their basic needs. This finding adds merit to Miller and Rasmussen’s (2010) theory that daily stressors are a strong influence on mental health and wellbeing and as such, cannot be neglected as a discrete variable in researching or supporting the mental health and wellbeing of conflict-affected populations. Naturally, this has important implications for people and organisations wishing to research and work in post-war contexts, which are explored in greater detail in the following sections.

7.4 Practical implications of the findings

The current research has a range of implications across disciplines and practices. There are learnings from this investigation where recommendations can emerge for professionals engaged in the study of cross-cultural mental health, particularly in developing and post-conflict contexts. There are also some fundamental considerations for psychologists and humanitarian organisations working in such contexts.
7.4.1 Practice implications for mental health research across cultures

It remains incontrovertible that the practice of research across cultures, particularly in post-war developing contexts is a formidable and ambitious undertaking. Ordinary measures and psychological constructs such as acculturative stress (Berry, Kim, Minde & Mok, 1987) or social support (Harber, Cohen, Lucas & Baltes, 2007; House, 1981; Hobfoll et al., 2007; Procidano & Heller, 1983) take on different meanings in different cultures. It is clear therefore that any cross-cultural research must invest significant time, human and financial resources to ensure the appropriate validation processes of the concepts being measured and tools for their measurement (Alarcon & Foulks, 1995; Bolton, 2001; Inglby, 2005; Jones & Craddock, 1997; Kleinman & Cohen, 1997; Mollica, McDonald, Massagli & Silove, 2004; Porter & Haslam, 2005; Thakker & Ward, 1998; Summerfield, 1999). While this is well-known and logical, it is not so easily achieved in practice, as the current research demonstrated in its methodological challenges. In addition, such cross-cultural research cannot depend solely on quantifiable measures and needs to incorporate elements of qualitative and descriptive components.

In the current study, the qualitative data provided insight to social order, structure and function when the quantitative data could not decipher the influences of a specific social support construct. Similarly, the qualitative data offered unique insights to some of the nuances of the returnee experiences, while the quantitative data could not discriminate this difference. Furthermore, while the quantitative data revealed significant gender differences in the sample group, this was confirmed and understood in relation to cultural social structures through the qualitative analyses. These examples provide support to the importance of using mixed design methodology in cross-cultural mental health research.

It could be argued that from a pure epidemiological or psychopathological perspective, broader understanding about cultural perceptions of mental illness is not
necessary to ascertain mental health care needs and treatments (Klerman, Valliant, Spitzer & Michels, 1984). However, others would argue that this further risks undermining indigenous attitudes about mental health (e.g., in the current research there may be human rights vulnerabilities for people receiving mental health care), assumes a universal perspective of mental illness (Alarcon & Foulks, 1995; Canino & Alegria, 2008) and fails to allow for culturally unique presentations of the same disorders (Kleinman & Cohen, 1997; Lewis-Fernandez et al., 2010; Mbatia, Shah & Jenkins, 2009; Thakker & Ward, 1998; Vontress, 1999). For instance, based on the current research, it is likely that people experiencing depression-like mental illness will present with greater social withdrawal, ‘thinking too much’ about what they are lacking in their needs and possibly increased alcohol consumption, than subjective experiences of low mood, loss of pleasure in activities or feelings of guilt or unworthiness, which typify depression diagnoses according to the DSM-IV-TR (APA, 2000).

Treatment for depression without the cultural considerations may typically involve antidepressant medication or one-to-one therapy, neither of which would be readily available or necessarily appropriate to Southern Sudanese culture, which is more likely to seek practical, social or ‘magic’ traditional treatments. As such, the causes, presentations and idioms of distress and cultural traditions are essential to fully researching mental health and mental illness across cultures, and the qualitative nuances cannot be disconnected from the quantifiable measures of mental health needs. Thus, future cross-cultural research needs not only to work from a biopsychosocial framework of mental health and illness (Engel, 1977), but is likely to also require a multidisciplinary approach that incorporates non-mental health disciplines, such as sociology (e.g., to ascertain cultural meanings and understand gender roles), political science (e.g., to understand contextual influences) and history (Wessells, McKay & Roe, 2010).
The urgent need for targeted mental health research in developing countries, including culturally appropriate ways for the diagnosis and evidence-based treatment for people with mental illnesses is well documented (Saxena, Guillermo, Pratap, Ghassan & Ritu, 2006; Collins et al., 2011; WHO, 2004). The urgency is based on recent figures that indicate depression is about to become the world’s leading cause of disability by 2030 (WHO, 2008) and that the treatment gap for people living with mental illness in low and middle income countries is estimated to be as high as 80-90 percent (WHO, 2010). However, it is important that any research on mental health issues across cultures, languages and contexts is undertaken in ways that account for the inherent methodological challenges and the importance of reliable and valid research designs.

7.4.2 Practice implications for psychologists working in developing contexts

History has shown that good-willed mental health professionals, moved by the suffering of people in developing contexts, have descended upon those in need with virtuous intentions to improve their plight, but they have sometimes unwittingly caused more harm than good. Wessells (2009) documented a range of examples in humanitarian contexts where psychologists have shown cultural insensitivity to issues of insecurity or humanitarian actions, culturally inappropriate use of psychological interventions and use of individualistic treatment orientations rather than communal approaches to care. Wessells further described psychologists as often having an excessive and unhelpful focus deficits and victimhood that emasculate empowerment and resilience. Importantly, Wessells also criticised the use of short-term approaches that feed dependency and usually result in unsustainable programs that communities are unable to replicate or maintain after external assistance is withdrawn. There have also been reports that mental health initiatives have increased protection risks for individuals, including women and children, or contributed to community conflict.
The challenges documented by this research, and its results, clearly demonstrate that ‘typical’ psychological approaches to the identification and diagnosis of mental illness, treatment and systemic care requirements cannot be viewed as universally applicable. For instance, it may be normal practice for psychologists to encourage people to share feelings and ideas with their families, but this research has suggested this may be socially inappropriate. Also, it may be inappropriate in South Sudan to offer support such as counselling, without matching this with support for practical and material needs, which was seen as an important way for people to recover from mental or emotional problems. In summary, psychologists working in developing contexts must be critically self-reflective and culturally sensitive (Wessells, 2009), but also culturally competent.

Whaley (2008) acknowledged that the terms ‘cultural sensitivity’ and ‘cross-cultural competence’ have commonly been used interchangeably in the psychology literature, but historical reviews and multivariate analyses can decipher important distinctions between the two concepts. For psychologists working in diverse cultural settings, they will require more than mere sensitivity and knowledge about culture. They need to be competent to apply that knowledge and to work within the belief systems, traditional practices, social structures and contexts of those cultures. It may also require psychologists to contrive a different understanding of what their role as a psychologist may entail. For example, based on the cultural beliefs and treatments for mental illness outlined in this study, psychologists working in South Sudan would need to be aware of how family and friendship relationships differ, the subtleties of how depression might be identified through social engagement and that providing a diagnosis of mental illness in South Sudan may put individuals at risk of human rights abuses.

Furthermore, it is not enough for psychologists working in developing contexts to only be familiar with cultural practices related to mental health and wellbeing. Given the
strong links to mental illness and basic needs identified in this research and the unique social order in which men and women function in this society, psychologists cannot work in a silo of mental health care. Their work needs to be linked to the efforts of others in the communities working towards people gaining improved access to their basic needs, social support systems (e.g., women’s initiatives), human rights advocacy, livelihood programs to promote employment, returnee integration initiatives, education activities or even access to water programs – all of which have the potential to support improved wellbeing amongst these South Sudan communities. Therefore, psychologists working in the developing context would ideally be linked with a gamut of other programs, government institutions, non-government actors or community or faith based organisations. Such collaboration is a key recommendation of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support (IASC, 2007) and Wessells (2009). It also implied that links with the broader humanitarian actors is essential in the guidelines by Miller & Rasmussen (2010) who propose a stepped approach to determining individuals in need of specialised mental health care by ensuring people are initially supported to meet their daily needs or address their daily stressors before imposing clinical interventions. This has clear practice implications for psychologists working in developing contexts, but considerations from the humanitarian organisations can all be drawn from these findings.

7.4.3 Practice implications for humanitarian organisations responding to mental health needs in post-conflict and developing contexts

The links between lack of basic needs and mental illness, shown in this research and by others (Bolton & Batancourt, 2004; WHO, 2001, 2010; Jordans, Semrau, Thornicroft & van Ommeren, 2012), indicates that work towards the prevention, identification and treatment for people with mental disorder can no longer be ignored by the international non-
government organisation (iNGO) sector and those working in humanitarian organisations. From this research, some important implications for humanitarian practice can be gleaned.

This research has shown the importance of a thorough context and cultural analysis to help drive key research questions, and could also inform a mental health humanitarian response. For example, understanding the history of the Sudan’s political context, the indicators of poverty, the history and influence of tribal affiliations and Shilluk monarchy and the role of women has all helped to explain the current research outputs about social identity, social order and gender disparities found from the analyses. For iNGOs, it is not enough to simply list the community needs, but there is a need to have a full analysis of how locals construe and understand their own wellbeing, including their beliefs and attitudes about mental health, mental illness and its causes, symptoms, presentations and traditional treatment options. In doing so, humanitarian organisations will better establish culturally appropriate mental health programs and responses to the needs of people with mental illness. For example, the current research showed that social withdrawal was a key indicator that someone might be experiencing emotional or mental health problems, thus social withdrawal might be a good way for humanitarian workers to identify individuals who might be in need of a mental health referral.

The present research also revealed that there may be some serious human rights violations against people in South Sudan with severe mental disorder, and the risk of discrimination if individuals were identified as being mentally ill. This is not a unique phenomenon to South Sudan, but rather a well-established and documented problem in many developing countries (WHO, 2010). Humanitarian organisations can work towards greater advocacy on behalf of people with mental illness, which is consistent with the The Code of Conduct for International Red Cross and Red Crescent Movement and iNGOs in Disaster Relief (Sphere, 2011), to which the majority of humanitarian organisations subscribe. They
can build awareness of mental health issues in the communities, support anti-stigma and equality campaigns, advocate for improved services and rights-based approaches to treatment and care, and help communities to identify people who might benefit from mental health treatment.

The current research further supported the notion of local and traditional healing customs. Participants in this sample group identified that in addition to regular health care and prayer through their Christian faith, the local ‘magician’ or ‘witchdoctor’ was a common resource for treating people with mental illness. Humanitarian organisations would benefit from analysing such indigenous healing mechanisms and working towards building linkages and making them inclusive of mental health healing systems. Vontress (1999) and Kaplan (2009) have both observed that this often involves a more social healing process, inclusive of family or community supports and may be perceived as more holistic in African contexts. Wessells et al. (2012) studied a newly introduced child protection system in Sierra Leone and noted that it had failed in its task primarily because the implementers did not adequately account for traditional protection systems, which the local people preferred to use. Mental health programs in cultures like South Sudan could face similar challenges if the local perceptions about the causes, symptoms and treatments of the illness (or in South Sudan “the curse”) are not incorporated into treatments. In the current research, traditional treatments were seen as a supplement or addition to the primary health care system, thus there would also be the potential to link traditional healers with primary health care.

In South Africa, Peltzer (2009) describes how attempts have been made to incorporate traditional healers into the national health system and support a regulation system for traditional healers. The aim is to offer the population a dual-treatment process for physical and mental illnesses. While the medical doctors or specialists diagnose and treat the pathology, traditional healers support the mind-body structure by addressing possible
spiritual curses or practicing cleansing rituals; and both medical doctors and traditional healers are encouraged to work together under the South African national health system. This approach is not yet fully established, but positive steps have been made in South Africa to work with the two healing and health mechanisms and offers inspiration for the potential for humanitarian iNGOs working in South Sudan or other cultures to develop mental health programs alongside and inclusive of indigenous resources; which is another recommendation of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007).

It has already been noted that this research has demonstrated support for the basic tenets and framework of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007). This demonstrates that this is a critical guide for humanitarian organisations to follow when working in the humanitarian mental health and psychosocial support space; it can be a basis upon which mental health programs can be designed. For example, Figure 11 provides a representative example of how the analyses of the current research can be overlayed with the IASC Guidelines’ Intervention Pyramid.

As shown in Figure 11, the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (also referred to as “IASC Guidelines”, IASC, 2007) recommend that in order to encourage increased wellbeing and protect individuals from potential mental illness following crises, basic services and security need to be incorporated into mental health programs. Based on the analyses of the current research, humanitarian organisations might engage in advocacy to the government for sustained safety and peace, provide employment opportunities for people through livelihoods or economic development program, the direct distribution of food aid or water programs. Organisations might also work towards helping people with mental illness to restore their sense of safety by working towards greater realisation of human rights for people with mental
illness. At the next level, community and family supports could be enhanced through targeted social activities for youth or women, encouraging existing community groups to provide outreach supports for isolated individuals – all activities that can better support social inclusiveness and thus protection from mental illness, or treatment support if individuals begin to experience emotional or mental health problems.

Figure 11. Example of how data from the current research could be used to design a mental health program in South Sudan based on the Intervention Pyramid of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007)

The IASC Guidelines further recommend non-focused specialised supports, which, based on findings of the current research in South Sudan, might involve work to increase the capacity of existing structures, such as church groups, traditional healers or primary health care staff to provide more targeted evidence-based treatments, such as basic counselling.
Lastly, for more intensive care needs, humanitarian organisations could be working with existing health systems to improve psychiatric care and programs for people with severe mental illness, such as psychoses or severe depression. In all, the current research and analyses has shown some of the context-specific factors related to mental health care and needs in South Sudan, and a response could be planned using the framework of the IASC Guidelines.

Naturally, not all humanitarian organisations could be realistically expected to deliver on all of the programming needs identified in Figure 11. For example, a medical organisation might only focus on the top two layers of the intervention pyramid (focused non-specialised supports and specialised support), while other, perhaps more agricultural organisations, could work towards programs at the lower layers of the intervention pyramid (focused on basic needs and social supports). Regardless, the many and complex needs for a thorough mental health and psychosocial support program that any humanitarian organisation implements needs, at a minimum, to be linked, coordinated with and connected to each other so that each organisation can develop such integrated programs (IASC, 2007). Another benefit of ensuring strong coordination of mental health and psychosocial support programs in developing contexts is the greater potential for sustainability of work, through consultation, partnering and working alongside existing government, academia, community-based organisations or faith-based communities, which is more likely to ensure a long-term continuation of work once humanitarian organisations have left.

Approaches such as integrated programming, building community supports, emergency response coordination and local partnering are essential elements to humanitarian response, including responses in the health sectors (Burkle, 1999). Even though they require continued refinement in their implementation, concepts such as simple coordination with broader humanitarian actors has commonly been overlooked by non-humanitarian workers in
the mental health space (Wessells, 2009). This failing has been linked to lack of coordination and multi-disciplinarity (Wessells & van Ommeren, 2008) and contributed to the over-emphasis of mental disorder post-crises, trauma and trauma-focused interventions, standalone clinical services and the culturally or contextually inappropriate practice of mental health services or programs (Bolton & Batancourt, 2004; Ingleby, 2005; Miller & Rasmussen, 2010; van Ommeren, Saxena & Saraceno, 2005; Wesells, 2009). This further suggests that it is essential for the disciplines of psychology and humanitarian aid to continue working collaboratively towards greater care for mental health needs in developing countries (Wessells, McKay & Roe, 2010).

7.4.3a Returnee mental health care

Previous research about returnee mental health has largely focused on their trauma exposure, traumatic stress symptoms (Ingleby, 2005; de Jong, Mulhern, Ford, van der Kam & Kleber, 2000; Miller & Rasmussen, 2010; Porter & Haslam, 2005; Summerfield, 1999; van Ommeren et al., 2002; Weiss, Sacarceno, Saxena & van Ommeran, 2003), and their acculturation to new societies, predominantly their resettlement from developing to developed contexts (Berry, Kim, Minde & Mok, 1987; Berry, Phinney, Sam & Veddoer, 2006; Catwe, Bianchi & Kiloh, 1968; Neto, 1994, 2002a; Sondregger & Barrett, 2004; Steel, Silove, Phan & Bauman, 2002). Although this research could not distinguish returnees as having lower mental health than their host counterparts, or specifically experiencing acculturative stress, the findings that suggested returnees were experiencing some additional challenges compared with the host community has important implications for humanitarian organisations working in contexts where returnee resettlements are ongoing. Specifically, humanitarian organisations may need to provide additional supports and community programs to assist in returnee resettlement – not just from the perspective of their physiological needs, but also from the perspective of their wellbeing needs.
In developing contexts, the returnees are often supported with one-time returnee packages, such as basic agricultural tools or short term food supplies (UN & Partners, 2006). However, this research indicates that returnees may also benefit from targeted initiatives that support their reintegration to their homeland society. For example, returnees may benefit from establishing their own community support groups (see Figure 11) where they can begin rebuilding their social connections, share thoughts about changes they have noticed in their culture and ways they can practically find concrete solutions to their needs (e.g., employment opportunities). Such programs might also support returnees to manage their expectations of their return, particularly in light of returnees who had lived decades in asylum and had possibly become dependent on external support for meeting their basic needs.

Returnee needs will differ significantly in every crisis context, but this research has demonstrated that their attitudes, perceptions and social support processes may function differently to the systems that host communities have had opportunity to gradually adapt to over time. Thus, mental health and psychosocial support programs implemented by humanitarian organisations may need to acknowledge the unique vulnerabilities, and strengths (e.g., higher educational attainment) that returnees bring. Similar considerations will also be necessary for other potentially vulnerable groups, such as women.

7.4.3b Gender considerations in mental health care

Women have been shown in this research to be a particularly vulnerable group to higher symptoms of mental illness, less hopefulness about the future and greater dependency on others for finding ways to manage and control their life situations. In mental health research, this finding is consistent with previous inferences that women are more at risk of common mental health problems than men (Nwadiora & McAdoo, 1996; van Ommeren et al., 2002; WHO, 2003). In a similar vein, humanitarian organisations have also long-established that women, men, girls and boys have different needs following crises (IASC, 2006), but
women and girls are at a much greater risk of physical, sexual, labour and social violence and abuse (IASC, 2005).

In the South Sudan culture, the patriarchal nature of social norms that see girls married at young ages, inherited to new husbands, manage multiple/polygamous families and overall responsibility for household management, childcare and family harmony have no doubt contributed towards their reports of experiencing more symptoms of stress, anxiety and depression than the men who participated in the research. It therefore stands to reason that humanitarian organisations working in post-conflict South Sudan (or in the current conflict-affected South Sudan) need to pay special attention to the needs of women and girls in their humanitarian responses, including mental health and psychosocial support programs.

As suggested in Figure 11, greater support for women in South Sudan, or indeed a range of other humanitarian contexts (IASC, 2006, 2007) could be achieved through intentionally building up women’s social networks, so they receive greater emotional support amongst friends and potentially practical support from other women or resources in their communities. Such women’s support groups might also promote greater connections for employment or adult education opportunities, access to aid and humanitarian assistance. Mental health care for women could be increased by broader access to primary and maternal health care, which could be trained to respond to women’s mental health care issues alongside their physical health concerns. Such programs are likely to increase women’s increased access to basic needs, social supports and non-specialised supports (IASC, 2007), while organisations could also be working towards greater social equality for women through advocacy to government, men, employers or other service providers for women’s rights and protection (IASC, 2005, 2006, 2007).

Though it seems obvious that women require greater support and services, this remains a persistently neglected area of focus in both the mental health and humanitarian
sectors (USIP, 2011). The current research findings provide evidence, with significant effect-sizes, that gender needs cannot be ignored in South Sudan, and mostly likely, in all other mental health humanitarian programs. Furthermore, given the challenges often faced with providing mental health services for women, especially those impacted by sexual violence in conflict or post-conflict environments (IASC, 2005), it is clear that mental health needs of women is an important area for further investigation, amongst other issues that have emerged from the current research as warranting continued exploration.

7.5 Further research for mental health care in post-conflict and developing contexts

Mental health research in Africa and other developing contexts is known to be desperately lacking (Collins et al., 2011; Saxena, Guillermo, Pratap, Ghassan & Ritu, 2006; WHO, 2004). Although the areas of much-needed research needs are extensive, the current study has identified some specific areas that justify continued examination.

From these research findings, the influences of gender and mental health notably warrant greater investigation. Given the significant male/female disparities in mental health, targeted research about the specific mental health needs of women in particular cultural contexts should be encouraged. Simultaneously, all future mental health research needs to contribute to our appreciation of gender differences, and thus treat gender as a disaggregated and specific research variable. As such, the following areas identified for future research implies that gender would be an overarching factor for analysis and insight.

The evidence-informed Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007) were groundbreaking when they were introduced to the humanitarian sector (Wessells & van Ommeren, 2008). Slowly, the evidence base for their premise is growing but further replication is required; particularly in the psychology discipline where the complexity of humanitarian needs, cultural and contextual appropriateness of mental health needs is often
poorly understood (Wessells, 2009). The growing evidence of basic needs being a potentially greater risk factor for mental illness over and above direct experiences of conflict (e.g Miller & Rasmussen, 2010) also warrants further analyses. For example, a quantitative measure that offers a triangulation of findings from the current qualitative data about poverty being of greater concern than conflict in the South Sudan recovery context could be a powerful way to build upon the current findings; in addition to the utilisation of poverty-meaasures that have stronger validity, reliability and cultural/contextual application (Cooper, Lund & Kakuma, 2012; WHO, 2011).

Another area poorly understood by both psychology professionals and the humanitarian sector is the unique experiences of returnees resettling to their homelands. The physical needs of returnees is often addressed (albeit briefly, UN & Partners, 2006), but their psychosocial needs are either neglected or perceived to be the same as their host counterparts. However, this is unlikely given their experiences of asylum that usually involves separation from their cultures of origin and normal social support networks, different education or work experiences, and at times, greater dependence on external assistance for meeting their basic needs. Further research is needed to ascertain if the process of returning to the homelands is similar to an acculturative process observed by refugees migrating to developed countries (Berry, Kim, Minde & Mok, 1987) and ways this might be measured. Although there is a proliferation of research on refugees living in developed countries, greater investment is essential to the research of migrants, refugees and internally displaced populations living in developed countries – and those returning to their homelands – given these are the contexts where the world’s largest population movements occur (UNHCR, 2011).

Another measure and construct that could not be optimally ascertained in the current research is social support. Previous research clearly points to the importance of social supports as a protector from mental illness (Cohen & Hoberman, 1983) a resource for those
experiencing mental disorder (Broman, 1993; House, Landis & Umberson, 1998), a potential asset or capital (Woolcock, 1998); and the current research showed that it played an strategic role in the identification, causes and treatments for people with emotional or mental health problems. However, measuring social support in this South Sudan sample group proved problematic. To the author’s knowledge, there is not yet a widely-validated social support measure for cross-cultural adaptation and use. Since building social supports is a vital component of the IASC Guidelines (IASC, 2007), is known to be a vital link with mental health and wellbeing and in developing contexts, plays a potent role in all aspects of community life, such a measure would be indispensable for future researchers, psychologists working in developing contexts and humanitarian organisations responding to the mental health needs of crisis-affected populations.

In addition to the specific research needs about gender, the IASC Guidelines (IASC, 2007), returnees and the function and measurement of social support, a gamut of additional enquiries or initiatives is needed in post-conflict and developing contexts. For example, the DSM-IV-TR (APA, 2000) Cultural Formulation showed reasonable utility in the current research, but it was not deemed comprehensive enough in the South Sudan or research context. This creates is an opportunity for psychologists and humanitarians to work together to strengthen its efficacy across cultures and in non-western contexts. Participants in the current sample group showed minimal understanding about mental illness, often perceiving it dichotomously as a crazy-sane paradox. This suggests that greater awareness about mental illness in South Sudan, the rights of people with mental disorder and the ways communities can respond to their needs is necessary; and this need is most probably needed in other developing contexts also. Therefore, effective approaches for community awareness, anti-stigma campaigns and advocacy for the human rights of people living with mental disorder are all programs that could be implemented and measured for their effectiveness and
potentially built into models for use in an array of developing or post-conflict contexts.

Similarly, research into creating a strong evidence-base for culturally adaptable treatments for mental disorder (e.g., interpersonal therapy, psychopharmacology, cognitive behaviour therapy) is urgently needed (Collins et al., 2011) along with ways that traditional healing mechanisms can be productively incorporated into mental health care systems.

Finally, all cross-cultural research could be strengthened in its rigor. The current study revealed several limitations; already mentioned was sampling approaches, minimal materials for measurement, time and budget constraints to dedicate to fully and locally develop instruments as well as basic translation processes. Such challenges will continue to pervade research in developing countries, but future research proposals will need to justify the necessity of such needs to maintain consistency with global standards.
7.6 Conclusion

The notion that a primary driver for individuals to experience a sense of wellbeing is the need to feel safe, be sheltered and have access to their basic needs seems obvious; and such a theory has long been accepted as part of mental health knowledge. However, through the expansion of mental health research, literature and practice in high-income countries, this most primitive need has commonly been assumed in the evolving mental health research in developing and post-conflict countries. This research has supported the more recent and growing body of work in humanitarian mental health, which shows that for people living in extreme poverty, such as people in South Sudan, having access to their basic needs is directly associated with their mental health and wellbeing.

This research has also shown that in post-conflict South Sudan, a range of other factors appear to be contributing to wellbeing: the social support structures in which people live, gender roles, feelings of control and hopefulness about the future, the socio-political environment, individual experiences of war, trauma and migration and unquestionably, the cultural attitudes, beliefs and practices that underpin perceptions of mental health and wellbeing. These findings have important implications for future researchers in developing and post-conflict contexts, psychologists working in those contexts and humanitarian organisations responding to crises. Notwithstanding the breadth of variables that need to be considered in mental health work and research in developing and post-conflict countries, the basic day-to-day survival needs of people cannot be excluded as part of the mental health construct.
REFERENCES


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Miller, K.E. & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science and Medicine, 70*, 7-16.


*Enfance, 1*, 83-94.


Appendix A

Map of the Republic of the Sudan and The Republic of South Sudan

Research location: Malakal, Upper Nile, The Republic of South Sudan

Map downloaded from: [http://www.nationsonline.org/oneworld/map/sudan_map.htm](http://www.nationsonline.org/oneworld/map/sudan_map.htm) on 29 July 2013

The Sudan/Sudan-South Sudan border remains in contention as at the date of publication of this image. This map is used solely for the purpose of providing an indication of which states fall within the Republic of the Sudan and The Republic of South Sudan and to show the location of where the current research was conducted.
Appendix B

Research Interview Schedule

Interview Schedule

(Approx. 120 minutes per interview)

Demographic and ‘Basic Needs' Data (approx. 10-mins):

1. Male/Female
2. Do you know how old you are? [If no, can you guess how old you might be?]
3. Are you married? [If male: How many wives do you have?]
4. Do you have any children?
5. Do your children attend school?
6. Did you attend school as a child or adult?
7. To what level did you complete school?
8. What do you do for work?
9. What is the main source of your family income?
10. Can you describe to me the home where you live?
11. Who lives with you?
12. How many meals per day do you eat?
13. Do you commonly experience hunger?
14. Do you have access to a clean water supply? If yes, how far do you walk for water?
15. Do you have a local health clinic accessible in your area?

Qualitative Data (approx. 50 mins):

PART A: Free Listing Ethnographic Techniques (Bolton, Neugebauer & Ndogoni, 2002)

Note that the term “this community” will be used when speaking with people in southern Sudan or Kakuma refugee camp, but changed to “your community” when speaking with Sudanese living in Melbourne, Victoria
1. What do you see as the main problems that affect the people in this [or your] community?

2. How do you think people in this [your] community feel about their present situation?

3. What would be the signs that someone in this [your] community was experiencing emotional or mental health problems?

4. Seek further clarification on key mental health terms – what do these ‘locally prescribed disorders’ look like?

PART B: Questions related to DSM-IV-TR (APA, 2000) Cultural Formulation

1. To which tribe do you view yourself as belonging to?

2. Are there any other tribes or social groups you spend time with?

3. Who sets the rules and laws to which you and your family follow in your community?

4. Do you have any special names for emotional or mental health problems people in your community experience?

5. In your opinion, what causes emotional or mental health problems amongst people in this [your] community?

6. How would you go about finding treatment for someone with emotional or mental health problems?

7. How would your community react if someone had serious emotional or mental health problems?
PART C: Autonomic Control & Views of the Future

(Questions to be used as a guide, with probing or clarification questions at the researchers discretion)

We’d like to hear more about your personal life and journey. You can tell us as much or as little as you feel comfortable. Or if you’d prefer not to answer, that’s OK too.

1. Do you feel like you have control over what happens in your life?

2. When you think about your future, tell me how imagine your life is going to be in 2 years time?

3. Tell me how you imagine your life is going to be in 10 years time?

Thank the participant for sharing their personal information. Explain that we’re now going to ask a series of questions about how helpful they view their family and friends, their stress levels and common problems that many people who have experienced migration or war go through. We’ll guide you through each set of questions.

Following training with the translator, there is no need for the following questionnaires to be translated question for question. The translator will be able to ask the questions of the participant directly, in their own language, and record responses per participant. The researcher will remain with the participant and translator for any clarification questions and to monitor the process of questionnaire completion.

Perceived Social Support – Family (approx. 10 mins)

(Procidano & Heller, 1983)

Instructions: The following statements refer to feelings and experiences that occur to most people at one time or another in their relationships with their families. For each statement, there are three possible answers: Yes, No, Don’t know. To help you remember how you can answer, look at these pictures

(Pictures: green tick for yes, red cross for no, confused person for don’t know)
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
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</thead>
<tbody>
<tr>
<td>1. My family gives me a lot of encouragement</td>
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<tr>
<td>2. I get, practical advice from my family</td>
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<td></td>
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<tr>
<td>3. Most other people are closer to their families than I am to mine</td>
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<tr>
<td>4. When I share important, personal thoughts with the members of my</td>
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<td>family who are closest to me, it seems to make them uncomfortable</td>
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<tr>
<td>5. My family enjoys hearing about what I think</td>
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<tr>
<td>6. Members of my family share many of my interests</td>
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<tr>
<td>7. Certain members of my family talk to me when they have problems</td>
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<tr>
<td>or need advice</td>
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<tr>
<td>8. I rely on my family for emotional support</td>
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<tr>
<td>9. There is a member of my family I could talk to if I were upset or</td>
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<tr>
<td>discouraged, without regretting the conversation</td>
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<tr>
<td>10. My family and I express our opinions openly</td>
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<tr>
<td>11. My family is sensitive to my personal needs</td>
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<tr>
<td>12. Members of my family come to me for emotional support</td>
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<tr>
<td>13. Members of my family are good at helping me solve problems</td>
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<tr>
<td>14. I have very close relationships with several members of my family</td>
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<tr>
<td>15. I give good, practical advice to members of my family</td>
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<tr>
<td>16. When I share important, personal thoughts with members of my</td>
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<tr>
<td>family, it makes me uncomfortable</td>
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<tr>
<td>17. Members of my family like to spend time with me</td>
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<tr>
<td>18. Members of my family say that I am good at helping them solve</td>
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<tr>
<td>problems</td>
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<tr>
<td>19. Other people's families care about each other more than my family</td>
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<tr>
<td>does</td>
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<tr>
<td>20. I wish my family were much different</td>
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</tbody>
</table>
Perceived Social Support – Friendships (approx. 10 mins)

(Procidano & Heller, 1983)

Instructions: These questions are similar to the ones we just asked you about your family, but these statements refer to feelings and experiences that occur to people about their relationships with friends. Again, for each statement there are three possible answers: Yes, No, Don't Know. To help you remember how you can answer, look at these pictures (Pictures: green tick for yes, red cross for no, confused person for don't know)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
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</thead>
<tbody>
<tr>
<td>1. My friends give me the moral support I need</td>
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<tr>
<td>2. Most other people are closer to their friends than I am</td>
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<tr>
<td>3. My friends enjoy hearing about what I think</td>
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<tr>
<td>4. Certain friends come to me when they have problems or need advice</td>
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<tr>
<td>5. I rely on my friends for emotional support</td>
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<td>6. If I felt that one or more of my friends were upset with me, I’d just keep it to myself</td>
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<td>7. I feel that I’m on the fringe in my circle of friends</td>
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<td>8. There is a friend I could go to if I were just feeling down, without feeling funny about it later</td>
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<tr>
<td>9. My friends and I are very open about what we think about things</td>
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<tr>
<td>10. My friends are sensitive to my personal needs</td>
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<tr>
<td>11. My friends come to me for emotional support</td>
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<tr>
<td>12. My friends are good at helping me solve problems</td>
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<tr>
<td>13. I have a deep sharing relationship with a number of friends</td>
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<td>14. My friends get good ideas about how to do things or make things for me</td>
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<td>15. When I confide in friends, it makes me feel uncomfortable</td>
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<tr>
<td>16. My friends seek me out for companionship</td>
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<td>17. I think that my friends feel that I am good at helping them solve</td>
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</table>
18. Other people's friend relationships are more intimate than mine

19. I've recently gotten a good idea about how to do something from a friend

20. I wish my friends were much different

**Catwe Acculturative Stress Scale** (approx. 10 mins)

(Berry et al., 1987)

Instructions: These questions help us understand if you may or may not be experiencing stress. They talk about how you feel and what is going on in your body. For each statement there are three possible answers: Yes, No, Don't Know. To help you remember how you can answer, look at these pictures

(Pictures: green tick for yes, red cross for no, confused person for don't know)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
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<tbody>
<tr>
<td>1. Do you have pains in the heart or chest?</td>
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<td>2. Do you usually belch a lot after eating?</td>
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<td>3. Do you constantly suffer from bad constipation?</td>
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<tr>
<td>4. Do your muscles and joints constantly feel stiff?</td>
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<td>5. Is your skin very sensitive or tender?</td>
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<tr>
<td>6. Do you suffer badly from frequent severe headaches?</td>
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<td>7. Do you often have spells of severe dizziness?</td>
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<td>8. Do you usually get up tired and exhausted in the morning?</td>
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<tr>
<td>9. Do you wear yourself out worrying about your health?</td>
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<td>10. Do you usually have great difficulty in falling asleep or staying awake?</td>
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<tr>
<td>11. Do strange people or places make you afraid?</td>
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<tr>
<td>12. Do you wish you always had someone at your side to advise you?</td>
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<tr>
<td>13. Do you usually feel unhappy and depressed?</td>
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<td>14. Do you often wish you were dead and away from it all?</td>
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</table>
15. Does worrying continually get you down?

16. Are you extremely shy or sensitive?

17. Does it make you angry to have anyone tell you what to do?

18. Do people often annoy or irritate you?

19. Do you often shake or tremble?

20. Do you often break out in a cold sweat?

---

**Harvard Trauma Questionnaire** (approx. 20 mins)

(Mollica et al., 2004)

Instructions: We’d now like to ask you about your past history and how you are feeling today. You might find some of these questions difficult to answer or they might upset you. If so, please feel free not to answer.

**Part 4: Trauma Symptoms (screening for Posttraumatic Stress Disorder)**

Instructions: The following symptoms that people sometime have after experiencing hurtful or terrifying events in their lives. Can you tell us how much the symptoms bothered you in the past week, including today. You can answer in one of four ways – Not at all, A little, Quite a bit and Extremely. These four pictures will help you remember how you can respond (Pictures: Grass patch with nothing on it=Not at all; grass patch with three stones on it=A little, grass patch with 6 stones=quite a bit; grass patch with 9 stones on it=Extremely)

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Quite a bit</th>
<th>Extremely</th>
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</thead>
<tbody>
<tr>
<td>1. Recurrent thoughts or memories of the most hurtful or terrifying events</td>
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<tr>
<td>2. Feeling as though the event is happening again</td>
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<td>3. Recurrent nightmares</td>
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<td>4. Feeling detached or withdrawn from people</td>
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<tr>
<td>5. Unable to feel emotions</td>
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<td>6. Feeling jumpy, easily startled</td>
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<td>Description</td>
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<tr>
<td>7</td>
<td>Difficulty concentrating</td>
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<tr>
<td>8</td>
<td>Trouble sleeping</td>
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<tr>
<td>9</td>
<td>Feeling on guard</td>
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<tr>
<td>10</td>
<td>Feeling irritable or having outbursts of anger</td>
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<tr>
<td>11</td>
<td>Avoiding activities that remind you of the traumatic or hurtful event</td>
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</tr>
<tr>
<td>12</td>
<td>Inability to remember parts of the most hurtful or traumatic events</td>
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<td>13</td>
<td>Less interest in daily activities</td>
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<td>14</td>
<td>Feeling as if you don't have a future</td>
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<tr>
<td>15</td>
<td>Avoiding thoughts or feelings associated with the traumatic or hurtful events</td>
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<tr>
<td>16</td>
<td>Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events</td>
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<td>17</td>
<td>Feeling that you have less skills than you had before</td>
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<td>18</td>
<td>Having difficulty dealing with new situations</td>
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<td>19</td>
<td>Feeling exhausted</td>
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<td>20</td>
<td>Bodily pain</td>
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<td>21</td>
<td>Troubled by physical problems</td>
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<td>22</td>
<td>Poor memory</td>
<td></td>
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<td>23</td>
<td>Finding out or being told by other people that you have done something that you cannot remember</td>
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<td>24</td>
<td>Difficulty paying attention</td>
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<tr>
<td>25</td>
<td>Feeling as if you are split into two people and one of you is watching what the other doing</td>
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<tr>
<td>26</td>
<td>Feeling unable to make daily plans</td>
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<tr>
<td>27</td>
<td>Blaming yourself for things that have happened</td>
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<tr>
<td>28</td>
<td>Feeling guilty for having survived</td>
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<tr>
<td>29</td>
<td>Hopelessness</td>
<td></td>
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<tr>
<td>30</td>
<td>Feeling ashamed of the hurtful or traumatic events that have happened to you</td>
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</tbody>
</table>
31. Feeling that people do not understand what happened to you
32. Feeling others are hostile to you
33. Feeling that you no one to rely upon
34. Feeling that someone you trusted betrayed you
35. Feeling humiliated by your experience
36. Feeling no trust in others
37. Feeling powerless to help others
38. Spending time thinking why these events happened to you
39. Feeling that you are the only one that suffered these events
40. Feeling a need for revenge

### Hopkins Symptom Checklist-25 (approx. 10 mins)
(Mollica et al., 2004)

Instructions: We’re now going to read to you some symptoms or problems that people sometimes have. Can you tell us how much the symptoms bothered you or distressed you in the past week, including today. You can answer in one of four ways – Not at all, A little, Quite a bit and Extremely. These four pictures will help you remember how you can respond (Pictures: Grass patch with nothing on it=Not at all; grass patch with three stones on it=A little, grass patch with 6 stones=quite a bit; grass patch with 9 stones on it=Extremely)

### PART 1 - ANXIETY SYMPTOMS

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>A little</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Suddenly scared for no reason</td>
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<tr>
<td>2. Feeling fearful</td>
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<tr>
<td>3. Faintness, dizziness or weakness</td>
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<tr>
<td>4. Nervousness or shakiness inside</td>
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<tr>
<td>5. Heart pounding or racing</td>
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<td>6. Trembling</td>
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<tr>
<td>7. Feeling tense or keyed up</td>
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</tbody>
</table>
8. Headaches

9. Spell of terror or panic

10. Feeling restless or can’t sit still

### PART 2 – DEPRESSION SYMPTOMS

11. Feeling low in energy, slowed down

12. Blaming yourself for things

13. Crying easily

14. Loss of sexual interest or pleasure

15. Poor appetite

16. Difficulty falling asleep or staying asleep

17. Feeling hopeless about the future

18. Feeling blue

19. Feeling lonely

20. Thought of ending your life

21. Feeling of being trapped or caught

22. Worry too much about things

23. Feeling no interest in things

24. Feeling everything is an effort

25. Feeling of worthlessness

Thank the participant for their efforts and contributions. Ask how they are feeling and if they are upset by anything they have discussed during the interview. Provide them an opportunity to ask questions of us.

[End]
Appendix C

Signed Translator Confidentiality Agreement

Attachment 2 - Translator Agreement Form

Research Translation Training
I hereby acknowledge that I have undertaken training in the requirements for working as a translator for the psychological research to be undertaken on: The influences of basic needs, social support and migration on mental health: A study based on southern Sudanese culture.

Upon completion of this training, I understand that:
- Where possible, translation from the researcher to the participant, and vice-versa, must be as direct and possible and exact translations of what is said is to be provided;
- Where language differences do not permit an exact translation, this will be identified and explained to the researcher, with a description of what the words mean and how they would be understood in either language;
- It is important to translate only 1 to 2 sentences at a time, to ensure accuracy of information being passed along;
- If I do not understand what I am required to translate, I am required to ask clarification before translating back to the participant;
- I am to translate "in the first person";
- I am not to summarise or filter information, even if it relates to something I may be embarrassed about;
- I have a right to discuss with the researcher any content that I am not comfortable translating, and to provide reasons for that;
- When recording information from questionnaire responses, I am to record it honestly and accurately.

Confidentiality Statement
I fully understand the importance of maintaining confidentiality of information shared within the research interviews. I understand that I am bound to keep all information disclosed during interviews and about the research confidential from other World Vision staff, community members, authorities, my family and my friends. What participants say during interviews cannot be repeated or disclosed outside of the translator-researcher relationship. This will ensure the integrity of the research collected and protect all participants from potential harm, embarrassment or community exclusion.

If, at any time, I am requested to disclose information provided in the research interviews, I am to request support and advice from World Vision South Sudan staff.

Signed Consent

I, [Name of Translator], agree to act as translator for Ms Alison Schafer (World Vision Australia) as she undertakes a psychological study about The influences of basic needs, social support and migration on mental health: A study based on southern Sudanese culture. I understand that by doing so, I am bound to keep all information I hear from participants confidential and to directly exchange information shared through language translation. I have discussed the issues about confidentiality and the importance of accurate translation with Alison prior to interviews and agree to these aspects of my role in the research project.

[Signature]
Translator Signature

Date: 11/12/2008

[Signature]
Researcher Signature
Ms Alison Schafer

Date: 12/1/2008
Appendix D

Research Participant Verbal Consent Form

VERBAL CONSENT FORM

This form has been adapted from that used by Bolton, P. (2000) in Cross-cultural assessment of trauma-related mental illness. The John Hopkins University, U.S.A.

Instructions for the Interviewer: The following is to be read to the subject prior to the interview by the allocated translator. Through the translator, the subject may agree or disagree to participate in the study. If the subject agrees to participate, the researcher will sign on the line marked “Witness to Consent Procedures”. If the participant cannot write, they will provide a fingerprint to confirm their agreement.

Purpose of the Study:

You are being asked to part in a research study. We wish to find out about how southern Sudanese people are coping and how recent events in southern Sudan might impact your daily life and views about the future.

This research is being done through Swinburne University in Melbourne Australia, World Vision Australia and World Vision Southern Sudan.

Procedures:

To get this information, we are talking with southern Sudanese people who are living in south Sudan, Kakuma Refugee camp and in Melbourne, Australia. If you agree to participate in this research, we’re going to ask you a number of questions about your current situation, your cultural customs, your feelings and how you think about certain things. Some questions will be very short, while others may take a little longer.
You have the right to say no to participating in the interview if you feel uncomfortable, and you also have the right not to respond to any of the questions that you don't feel comfortable to answer.

**Risks and Discomforts:**

This interview will take about 2 hours. We are not going to try and upset you in any way, but it is possible that some questions may be uncomfortable or difficult for you to answer. Some questions may even make you feel sad as you reflect on your answers. If you feel you are getting upset at any stage during the interview, you may refuse to answer the question, take a break, or stop the interview entirely. We will also check in on how you are feeling throughout the interview process.

**Benefits:**

If you agree to speak with us, the information you provide will help World Vision to better understand your needs and maybe help us to develop better programs for people living in southern Sudan and those in the refugee camps. It will also help psychologists and other workers in Melbourne, Australia, to help southern Sudanese people adjust to life in the western world.

**Confidentiality:**

During the interview, we will be writing down information and tape recording our conversation. This is the information we will use for our study. When we finish talking with you and other participants, your personal information will be stored separately so that nobody can identify who you are. When it comes time to writing the report, we will combine your information with other peoples information so nobody will know how you personally answered the questions. This means that when the report is published others won't know who you are or which participant said different things. The only people who will know what you have said will be [translator] & [Interviewer].

**Voluntariness:**

It is your decision whether or not to be part of this study – you can also stop your involvement in the interview at any time. This will not affect any assistance you receive from World Vision now or from any other organisation or
group. This interview is quite separate to the other programs you may or may not be involved in with World Vision.

Whom to contact:

If you have any questions you can ask Alison Schafer from Swinburne University, or [First name & Surname of Translator]. We can both be contacted through World Vision’s staff.

If you feel that this interview has caused you to become upset or affects the way you participate in your community or family, you can talk with World Vision staff about this at any stage in the future.

Do you have any questions about the interview?

Do you understand this information just read to you?

Do you agree to participate in the study?

<table>
<thead>
<tr>
<th>Participant Consent – Signature or Fingerprint</th>
<th>Witness to Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(to be signed by researcher)</td>
</tr>
</tbody>
</table>

Date
Appendix E

Symbol cues used with participants for the administration of the Perceived Social Support Scales for Family and Friends (Prociando & Heller, 1983) and the Catwe Acculturative Stress Scale (Berry et al., 1997)

Symbol guides

Yes  No  Don’t Know
Appendix F

Picture cues used with participants for the administration of the Harvard Trauma Questionnaire (Mollica et al., 2004) and the Hopkins Symptom Checklist-25 (Mollica et al., 2004)

Picture guides

Not at all  A little  Quite a bit  Extremely
Appendix G

Samples of Prompting and Clarifying Questions used during Qualitative Research

Based on interview transcripts, the following is a random selection of common prompting questions posed to participants to encourage greater detail in their responses, clarify ideas and seek out additional information.

- And how regular is that work? How many days per week does he do hand work or daily work?
- What does that mean? What kind of work is that?
- Any other tribes?
- What else are problems in this community?
- What else do you think affects people in this community?
- When you walk around the streets, what problems do you see?
- What kind of problems do those who are not working have?
- There is actually no right or wrong answer. This is just asking what you see or what you think, so you can just speak whatever is on your mind.
- Are there any other signs of mental or emotional health problems?
- You mentioned too that people would be walking around confused. How might someone with that confusion behave?
- Can you think of any other signs that might indicate someone might have emotional or mental health problems?
- Can people have emotional or mental health problems without being violent?
- So that is the name of the person. Is there name of the illness? What is the name for the disease?
Tell me, many people in Sudan feel unfortunate about what they don’t have and I imagine many people are treated badly in their families. So why do some people have mental health problems and others do not?

What else might the community do?

What if none of those treatments work? What would the community do?

What might the government do to help treat someone with a mental health problem?

So at what point would someone be considered a madman and left to take care of himself versus someone who is just isolated and requires advice?

Would they be excluded from community life?

Is there anyone else responsible for what happens in your life?

Can you give me an example of some of those things that are impossible to solve?

So can you tell me something that is small that you have control over and something that is big that you don’t have control over?

How do you think it might be better?

How do you hope it will improve?

So can you explain a bit more about that?
Appendix H

Letter of Attestation outlining the Procedure and Declaration of the Independent Auditor of the Qualitative Research Themes

This letter of attestation relates to the independent audit of the dissertation, by Alison Schafer, on the topic of the influences of basic needs, social support on mental health and wellbeing in South Sudan. The purpose of this audit was to review the qualitative information collected as part of the research project and to verify the themes the author assigned to the response provided by the participants. The notion of an independent audit follows similar concepts underpinning fiscal audit processes where an impartial agent examines the data for authenticity and to determine that information reported in the research results are an accurate representation of the data.

The audit procedure

The independent audit was carried out following the authors’ allocation of thematic concepts drawn from the qualitative data. The audit consisted of the following actions by the agent:

- Authentication that the data used for thematic analyses were exact statements sourced from the original transcripts of the research interviews;
- Appraisal of the themes devised, including the representativeness of those themes (in relation to the data obtained) and the suitability of the thematic explanations as being a truthful interpretation of those themes; and
- Verification that each statement in relation to specific research questions were systematically, appropriately and objectively allocated the most acceptable theme or themes.
Where the independent audit considered participant responses to be representative of a different theme from those of the author’s, these individual cases were discussed and adjusted accordingly.

_The audit declaration_

The independent auditor signed this Letter of Attestation, attesting that:

All information used for thematic analysis in this research was a true and accurate reflection of original transcripts. Each theme was reviewed and evaluated as being an appropriate reflection of information research participants provided to the interview questions. Each statement was reviewed to ascertain its appropriate and accurate allocation to one or more themes presented in the research results. I hereby testify that the transcripts and thematic analysis were systematically coded and that the qualitative data, presented by Alison Schafer in this dissertation, are a true and objective reflection of information obtained from research participants.
Appendix I

Letter of Support for Research from World Vision South Sudan Programs Director

5th February 2007

SBS Research Committee
School of Social & Behavioural Sciences
Mail H24
Swanbourne University of Technology
Hawthorn Vic 3122

To whom it may concern,

I am writing to confirm that I have spoken with Aliona Scharfe from World Vision Australia about her proposed psychological study on "The Influence of Basic Needs, Social Support and Migration on Mental Health: A study based on southern Sudanese Culture". Aliona has presented to me an outline of her study, in addition to the proposed measures and methodology, which is now pending ethics approval from Swanbourne University.

In conjunction with plans for Aliona to visit southern Sudan in the next 12 months, for standard World Vision project monitoring, I am pleased to advise, on behalf of World Vision southern Sudan, that we are in agreement and supportive of Aliona undertaking her psychological study and provide assistance by way of translators and access to communities with whom World Vision works.

We appreciate the specific details of timing and logistics are yet to be defined, but consent to collaboratively working through these issues when the time of data collection draws near is hereby provided.

World Vision southern Sudan looks forward to supporting Aliona in this psychological study and the subsequent findings in her research about mental health amongst the southern Sudanese people.

Yours sincerely

Simon Helico
Programs Director
World Vision southern Sudan

World Vision is a Christian organisation reaching out to a hurting world • ACN 024 779 081 • ABN 28 024 779 961
Appendix J

Letter of Support for Research from the South Sudan Relief & Rehabilitation Commission (SSRCC) – Upper Nile State Headquarters

TO WHOM IT MAY CONCERN

Ms. Alison Schafer works for World Vision in Australia. She came to Malakal on research in the field of Trauma. Moreover, to assist her field office in Upper Nile on how to strengthened the aforementioned department.

We recommend your cooperation to render any kind of support she may need.

Regard,

SSRCC State Director
Upper Nile State, M.R.K.