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SCARS OF WAR

Mental Health & Wellbeing of Patani Migrant Youths in Malaysia

SCARS OF WAR - Mental Health & Wellbeing of Patani Migrant Youths in Malaysia

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CONTENTS

GLOSSARY

Anxiety	A feeling of worry, nervousness, or unease about something with an uncertain outcome.
Correlational Analysis	Is statistical method that is used to discover if there is a relationship between two variables/datasets.
Cross-Sectional	Constituting a typical or representative sample of a larger group.
Diagnosis	The identification of the nature of an illness or other problem by examination of the symptoms.
Depression	A mental condition characterized by feelings of severe despondency and dejection, typically also with feelings of inadequacy and guilt, often accompanied by lack of energy and disturbance of appetite and sleep.
Detention	The action of detaining someone or the state of being detained in official custody.
Complex Post-Traumatic Stress Disorder	Is a condition where you experience some symptoms of PTSD along with some additional symptoms, such as: difficulty controlling your emotions, feeling very angry or distrustful towards the world.
Generalized Anxiety Disorder	A disorder characterized by excessive or unrealistic anxiety about two or more aspects of life (work, social relationships, financial matters, etc.), often accompanied by symptoms such as palpitations, shortness of breath, or dizziness.
Major Depressive Disorder	A mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts.
Post-Traumatic Stress Disorder	A condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world.
Mental Disorders	Are conditions that affect your thinking, feeling, mood, and behavior. They may be occasional or long lasting (chronic). They can affect your ability to relate to others and function each day.
Mental Health	A person's condition with regard to their psychological and emotional wellbeing.

Pondok	A traditional Islamic educational institution focuses on the study of Islamic knowledge.
Post-Migration	Post migration is the final stage in which refugees are relocated to a host country, where they could potentially seek asylum.
Pre-Migration	Existing or occurring before a migration.
Phychosis	A severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality.
Psychological	Of, affecting, or arising in the mind; related to the mental and emotional state of a person.
Psychological Distress	Refers to non-specific symptoms of stress, anxiety and depression.
Qualitative	Relating to, measuring, or measured by the quality of something rather than its quantity.
Quantitative	Relating to, measuring, or measured by the quantity of something rather than its quality.
Binary Logistic Regression	The target variable is binary, that is, it can take only two values, 0 or 1.
Linear Regression	Used to predict the value of a variable based on the value of another variable.
Stress	A state of mental or emotional strain or tension resulting from adverse or demanding circumstances.
Torture	The action or practice of inflicting severe pain or suffering on someone as a punishment or in order to force them to do or say something.
Trauma	A deeply distressing or disturbing experience.
Dependent Variable	A variable (often denoted by Y) whose value depends on that of another cross-sectional constituting a typical or representative sample of a larger group.
Independent Variable	A variable (often denoted by X) whose variation does not depend on that of another.

HIJRAH PAKSA

by Basman Dewani

Sesuatu telah mengubah hala tuju hidup ku
Ubah matlamat hidupan ku
Mengubah cerita ku
Mengubah... mengubah segala-galanya dalam kehidupan ku
Yakni, Hijarah Paksa aku di negeri orang...

Kerana...
Aku keliru tentang di negara sendiri apabila aku di sana
Di negeri ini yang berada di ambang kehancuran
Mereka yang berkuasa semakin berjaya
Yang lemah semakin menderita
Terdapat banyak kes kejahatan yang belum selesai
Keadilan yang tidak akan terpakai...

Undang-undang negara aku hanya undang-undang paksaan
Tetapi kamu tidak akan dapat melihat dengan dua belah mata
Orang yang tidak berdaya menjadi Kambing Hitam
Mereka di masukan penjara dengan penghinaan
Mereka dibunuh seperti binatang yang tidak berharga
Tiada siapa yang berani melawan
Semua tertakluk kepada penerimaan realiti dan peraturan...

Keadilan...
Kemana kamu pergi hilang tanpa tujuan
Aku dibuli apabila kamu hilang tanpa tujuan
Dibuli dengan teruk sekali
Aku tidak tahu berapa lama aku akan dipenjarakan
Tanpa harapan lagi dengan hanya berdiam...

Apabila fajar menjelma
Aku tersingkir
Saat matahari terbenam
Aku masih terabai...

Aku sangat takut
Dan menakutkan
Dengan penuh ancaman
Di bawah kuasa seragam hitam dengan senapang...

Aku memilih jalan keluar untuk berhijrah
Berhijrah paksa ke negara orang Kerana aku telah hilang arah
Arah keadilan
'Keadilan' di negara ini kini
Semuanya hilang tanpa tujuan
Kepada siapa?
Apa yang akan aku harus tuntut dan suarakan?

ACKNOWLEDGEMENT

Malaysia at its essence is indeed a gathering place of people from around the region, and has been so for centuries – historically it was due to our maritime civilisation, porous borders coupled with fertile land. Today, it is our economy and industrialisation coupled with a multicultural society, that makes us attractive. We are indeed a cosmopolitan society. In embracing cosmopolitan ideals, Malaysia must also accept the fact that we have become a destination of refuge for many fleeing violence and oppression, the landscape of irregular migrants consists of multiple types of irregular migrants from refugees fleeing genocide on boats to those fleeing violence via tourist visas.

This study is a continuation of our previous report on the exodus of youths fleeing Southern Thailand to Malaysia since 2004. Very little is known about this community in Malaysia apart from the fact that many youths work in Tom Yam restaurants, their ability to subtly integrate within Malaysian society has allowed them to contribute towards Malaysia's social and economic fabric with very little resistance from the host community. If only other refugees and asylum seeking communities are given the same chance, IMAN believes that they too would positively contribute to Malaysia. Nevertheless, any community running away from armed conflict or violence would bring along with them the impact of that violence. It is hoped that this study will highlight some of the challenges faced by the Patani youth community here and despite their challenges they have been able to survive and thrive.

This study would not have been possible without the trust, support and friendship of the Patani-Muslim community here in Malaysia as well as in the Deep South. Many individuals and organisations had assisted us in this journey. IMAN Research would like to extend our sincere thanks to all of them, especially PENAJA and Mr. Benyamin whose team of volunteers had helped us in the critical work of data collection. We are highly indebted to the Sasakawa Peace Foundation for trusting IMAN Research to conduct this study, and without their support this report would not have been feasible. To Dr. Akiko Horiba, *terima kasih* for your continued guidance, support and trust.

Lastly, much appreciation also goes to the research team in developing this report and people who have willingly helped us along the way.

Thank you.

ALTAF DEVIYATI
MANAGING DIRECTOR

INTRODUCTION

According to evidence, one person in every five – 20 percent – of people who live in conflict zones have some form of mental health issue (ICRC, 2021). Hence, in a conflict affected area, people suffer from mental health issue three times more than the general public and this is not just an issue of prevalence but an issue of access. Hence, peacebuilding, mental health and psychosocial support are strongly interconnected. People who have lived through armed conflict, suffered losses from losing family members to being attacked themselves tend to carry grievances and wounds that can impact their lives and the community around them if left untreated no matter where they are. Today, those who are fleeing from armed conflict use many methods, some seek refugee status while others as skilled or semi-skilled migrants.

In 2019, it was estimated that the global number of international migrants was 272 million people, 51 million more than that in 2010. This constituted about 3.5% of the total global population and is certainly likely to continue to grow. Many people leave their home countries for work, but millions more had to flee their homes due to conflict, violence and climate change. Yet, international migrants continue to be perceived negatively, many countries make it difficult for migrants to live and work by having harsh migrant policies. It is even more difficult for irregular migrants, many do not understand the complexity of migration and the challenges faced by irregular migrants.

According to International Organization for Migration (IOM), the term migrant is an umbrella term that is not defined under international law but refers to the following – "reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons". Irregular migrant is another term without a universal definition that refers to the movement of people or person outside existing legal regimes, again defined by IOM as "... the movement of persons that takes place outside the laws, regulations, or international agreements governing the entry into or exit from the State of origin, transit or destination". Based on this we can broadly group irregular migrants into four categories: (a) illegal entries who travel without valid travel documents, (b) a person not authorised to work within a particular country due to not having a valid working document, (c) those who overstay by surpassing their expiry date to be within the borders of a country and (d) refugees and asylum seekers (Loh, Simler, Tan, & Yi, 2019).

Based on the 2019 International Migrant Stock, a dataset released by the Population Division of the UN Department of Economic and Social Affairs (DESA), three out of every four international migrants are of working age. In 2019, 202 million international migrants, equivalent to 74% of the global migrant population, were between the ages of 20 and 64 and this includes Southeast Asia. Hence, they would either be at the prime of youth with great potential or seasoned skilled workers.

Malaysia's economy is heavily dependent on cheap labour from predominantly neighbouring low-income countries as well as those from South Asia. The majority come to Malaysia to seek economic opportunities while a substantial number of irregular migrants come to Malaysia seeking protection from violence, persecution and violations from their home country (IOM, 2021). Between 2010 and 2017, the number of documented or regular foreign workers in Malaysia increased from 1.7 million to 2.2 million (IOM, 2021). Majority of foreign workers in Malaysia come from Indonesia followed by South Asia countries - Nepal and Bangladesh, Philippines and Myanmar (Loh, Simler, Tan, & Yi, 2019). When it comes to irregular migrants, it is difficult to get precise and accurate figures since very little is known but based on a World Bank

study, it is estimated that in 2017 the number of irregular workers was around 1.2 million while the total foreign migrant workers about 3 million but unofficial data suggest that there are as many as four million irregular migrant workers (Loh, Simler, Tan, & Yi, 2019).

The presence of Patani community living and working in Malaysia is not new especially in the northern states of Kedah and Perlis as well as east coast states of Kelantan and Terengganu. However, since 2004 after the Tak Bai massacre and Krue Se Mosque standoff, we have seen a rise of young adults coming to Malaysia. As mentioned in the Youth Exodus: Forced Migration of Youths from Southern Thailand Towards Malaysia report, there is strong evidence to show that there is a significant number of irregular migrant workers from Southern Thailand working in Malaysia and that the numbers have been steadily growing post-2004.

The current official data does not give the full picture of the community of Thai migrant workers in Malaysia, in particular those from the Southern provinces. It also does not correlate with evidence from other literature that suggest there has been a significant increase in the number of migrations from Southern Thailand to Malaysia. Based on observed patterns, it is assumed that there is a high number of irregular migrant workers in Malaysia who enter using tourist visa/pass and work in Malaysia illegally (World Bank, 2019). Apart from being predominantly irregular migrants, there is also strong evidence to suggest that most of the migrants from Southern Province are youths who are not only in search of employment but also refuge and respite from being targeted by security forces in the South.

The impact from the ongoing violence in Southern Thailand towards youth and children are significantly under-studied. Little is known on how the violence has affected youths, especially during their formative years. Children who were born in 2004, the year of the Tak Bai massacre and Krue Se Mosque stand-off would be 18 years old in 2022. This would mean that they would have grown-up during one of the most violent times of conflict, yet we know very little of how this has impacted them.

Hence, this study intends to highlight how the violence in the south have affected Patani youths, specifically those who seek employment as migrants in Malaysia.

This report will highlight

1. Pre-migration trauma coupled with post-migration living difficulties in Malaysia contribute to psychological distress (PTSD, depression and anxiety) as well as perceived health;

2. Migrants with a history of being tortured and detained are significantly more vulnerable towards psychological distress; and

3. Regardless of legal status, growing up as a migrant in Malaysia puts a person at a higher risk of PTSD. This may also imply that post-migration stressors have a long term effect on family dynamics.

This report will further highlight the plight of Patani migrant communities and the post-migration challenges they face. We believe that this report will benefit the community by paving the way for future prevention and intervention programmes, policy recommendations and other appropriate psychosocial services.

BACKGROUND

In early 2021, IMAN conducted a landscape analysis to investigate whether the 2004 Tak Bai massacre and subsequent security policies put in place by the Thai Military within the Deep South had affected the movement of youths from Southern Thailand to Malaysia. Youths in this context are those below the age of 35 years old and who moved to Malaysia after 2004 whether individually or with family. The landscape also identified what were the strengths and challenges that Patani youths faced while in Malaysia as a community by using the Communities Advancing Resilience Toolkit (CART), particularly the field-tested community resilience survey. The landscape came to four main conclusions; firstly, based on qualitative evidence, youth migration to Malaysia was indeed a flight strategy as a result of the escalation of the violence in the Deep South, particularly those that specifically targeted youths. Second, the Patani youth's community perceives their main strength is in their sense of belonging - their Patani identity. Third, the biggest challenges faced by them is their limited ability in harnessing their collective resources as a community working and living in Malaysia and finally, the fourth conclusion showed that there is a gender component on - while in terms of aggregated numbers, there are more male than female youths moving to Malaysia, nevertheless, young women are also fleeing the Deep South. According to reports an overwhelming number of women are soft targets, amounting to 16% to those killed or injured by 2016. To add, the rise in women who have to take over the role of breadwinner as their husband, brother or father are either detained, murdered or joined the insurgency is pushing them to become irregular migrants in Malaysia.

A key outcome from the landscape analysis was the critical need to have further data on the impact of violence on cross-border migration and its impact on mental health and general wellbeing, of the community in Malaysia as the landscape analysis suggests that there are signs of trauma, stress and anxiety among the community.

Therefore, in this study, IMAN intends to assess psychological and overall wellbeing of working-aged youths migrating from the deep south to Malaysia, a community that is transient and fluid, moving between Southern Thai and Malaysia.

IMAN Research with PENJANA and workshop participants

MIGRANTS, REFUGEES AND MENTAL HEALTH

According to the World Health Organization (WHO), the most vulnerable among international migrants in need of protection and support are refugees, asylum seekers and irregular migrants. They are usually exposed to various stress factors which affect their mental health and wellbeing before and during their migration journey and during their settlement and integration. The prevalence of common mental disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD) tends to be higher among migrants exposed to adversity and refugees than among host populations. Yet, many migrants and refugees lack access to mental health services or experience barriers in accessing these services.

The process of migration usually involves people adapting and adjusting according to their new environment (Bughra, 2004). Migrants are found to have specific mental health risk factors that affect their overall health and psychological wellbeing. This includes factors such as exposure to stressful and traumatizing conditions such as violence, discrimination, abuse by authorities, forced separation from family or homeland, harassment, assault, detainment, and even deportation in some cases (McCabe, Mosley, Everly, Links, Gwon, Lating & Kaminsky, 2008). Distress among migrant individuals is a common occurrence and this could be related to the individual's lack of preparedness or adaptation to new environment and lifestyle (Beiser & Hou, 2016). The process of migration could be challenging especially for youths as they are young and vulnerable to their surroundings.

Developmentally, youths are still in the age range of identifying their own uniqueness and learning to adapt to the environment and define their own identity (Hayes & Endale, 2018). The challenges and issues faced by migrant youths are usually during the post-migration stage. Studies have shown that psychological distress experienced during the post-migration stage does affect the mental health of the migrants (Kaur et al., 2020).

About one out of three refugees experience high rates of depression, anxiety, and post-traumatic stress disorders (PTSD) (Turrini et al., 2017). Psychological distress often happens to those who regularly experience events that are very stressful (Beiser & Hou, 2001). It is a psychological condition of emotional disturbance characterized usually by anxiety and depression symptoms. It is also a common term used to describe emotions or feelings that are unpleasant, which affects one's functioning.

Psychological distress is also recognized as emotional distress that stems from demands and stressors that one finds very difficult or unable to cope with in their daily life (Arvidsdotter, Marklund, Kylen, Taft, & Ekman, 2016). In migrants, psychological distress can be further understood by taking into consideration the pre-migration and post-migration stages. Studies have found that pre-migration and post-migration factors are highly associated with psychological distress among migrants (Thapa, Dalgard, Claussen, Sandvik, & Hauff, 2007). Psychological distress is also found to be commonly associated with both negative pre-migration experiences and post-migration experiences (Taloyan, Johansson, Sundquist, Kocturk, & Johansson, 2008). Nakash, Nagar, Shoshani, Zubida and Harper (2012) identified that youth migrants are also more vulnerable and likely to develop risk factors that cause psychological distress. Fazel et. al., (2005) conducted a systematic review and meta-analysis of refugees resettled in high-income countries, covering the period 1986–2004, and reported a prevalence of 9% for posttraumatic stress disorder (PTSD), 5% for major depressive disorder, and 4% for generalised anxiety disorder, based on studies reporting at least 200 participants (Fazel et al., 2005).

According to Pumariega, Rothe and Pumariega (2005), pre-migration and post-migration experiences tend to play an important role in the risk of developing mental health problems among migrants. Schweitzer, Brough, Vromans and Asic-Kobe (2011) further stated that pre-migration traumatic events such as witnessing or experiencing traumatic events are a known cause of psychological distress among migrants. These traumatic experiences are usually associated with mental health problems such as anxiety and

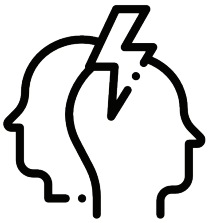
depression (Birman & Tran, 2008; Keller, et al., 2006). A study of Vietnamese refugees resettled in Australia showed pre-migration traumatic life events to be an important contributor to depression and anxiety (Steel, Silove, Phan, & Bauman, 2002). Migrants who have experienced traumatic events during the pre-migration stage are at risk to have psychological impacts such as depression (Bhui, et al., 2003). Recent studies have also found that traumatic events experienced during pre-migration have a lingering effect on one's mental health (Schweitzer, Melville, Steel, & Lacherez, 2006; Gong, Xu, Fujishiro, & Takeuchi, 2011). Post-migration stressors such as prolonged detention, insecure immigration status, and limitations on work and education, can worsen mental health (Li et al., 2016). Refugees may have been exposed to traumatic events such as conflict, loss or separation from family, a life-threatening journey to safety, long waiting periods for legal migration processes, and complexities with acculturation (Beiser, 2006; Porter & Haslam, 2005). A sizable proportion are therefore at risk of developing psychological symptoms and major mental illness that can persist for many years after resettlement (Bogic et al., 2015).

Current literature also suggests that post-migration living difficulties also affect individuals' psychological wellbeing (Schweitzer, Brough, Vromans, & Asic-Kobe, 2011). It was found that post-migration stressors are known to be one of a significant determinant of mental health problems (Silove & Ekblad, 2002). Schweiter, Melville, Steel & Lacherez, 2006 found in their study that anxiety was also linked to the level of post-migration difficulties. These post-migration living difficulties can also become chronic and may lead to poor quality of life (Porter & Haslam, 2005). A study that was conducted in Sweden among the refugees reported that post-migration stressors are difficult to cope with (Samarasinghe & Arvidsson, 2002). Studies that were conducted in the Netherlands, Canada, and Australia found that post-migration living difficulties were associated with psychological distress like depression and anxiety (Gerritsen, et al., 2006; Schweitzer, et al., 2006; Simich, et al., 2006).

Stress conditions such as exposure to trauma experiences had also been found to be associated with the risk of developing mental health disorders such as posttraumatic stress disorder (PTSD), major depressive disorder, and psychosis (Subedi, Li, Gurung, Bizune, Dogbey, Johnson & Yun, 2015). Countless studies have further strengthened our understanding on the prevalence of mental health disorders especially PTSD among migrants (Giacco & Priebe, 2018; Sangalang, Becerra & Mitchell, et al., 2019). However, limited findings can be identified in relation to the prevalence of complex PTSD in the migrant population. Herman (1992) stated that complex PTSD begins due to prolonged and repeated interpersonal trauma wherein the prevalence of trauma within a social context permits abuse of power or exploitation of the victim and the trauma is always relational in nature. The presence of repeated trauma that is more interpersonal in nature significantly influences the victim's wellbeing and thus making it more complex as compared to the effect of single trauma exposure which is often the case with PTSD. According to the findings of De Silva, Glover & Katona (2021), although previous studies do reveal the significant prevalence of complex post-traumatic stress disorder (CPTSD) among treatment samples, there is still a lack of research focused on determining the prevalence of CPTSD in migrant populations including refugees and asylum seekers.

The migrant population is often the unheard and underprivileged community in many nations; therefore, they often feel that they have no rights or voice in the society (Jernigan, Jacob & Styne, 2015). Many of their needs for basic health, safety, and psychological needs are not met and thus they often feel not listened to. It is also to be noted that the vast majority of research investigating post-migration psychological distress on migrants has been focused on adults in general thus ranging from as young as 18 to 60 years and above (United Nations, 2013). There is very little research and data on understanding the post-migration psychological distress impact among the youth migrants. Addressing this issue will provide insight to improve the quality of life of migrant youths and provide effective social support. Other than that, limited research has also been carried out on understanding the prevalence of psychological disorders such as PTSD and CPTSD among migrants in Malaysia.

This limits our understanding of the psychological needs of migrants, especially the youth migrant population. Moreover, there is a very limited number of studies that have been carried out on the Patani youths Migrant in Malaysia. This could cause this population of migrants to endure some unaddressed issues that they may need appropriate support for. This study is designed to contribute to the existing literature on the living condition and need for psychosocial support of Patani youth Migrants in Malaysia and further research.



Sharing session between participants and Altaf Deviyati

OBJECTIVE AND CONCEPTUAL FRAMEWORK

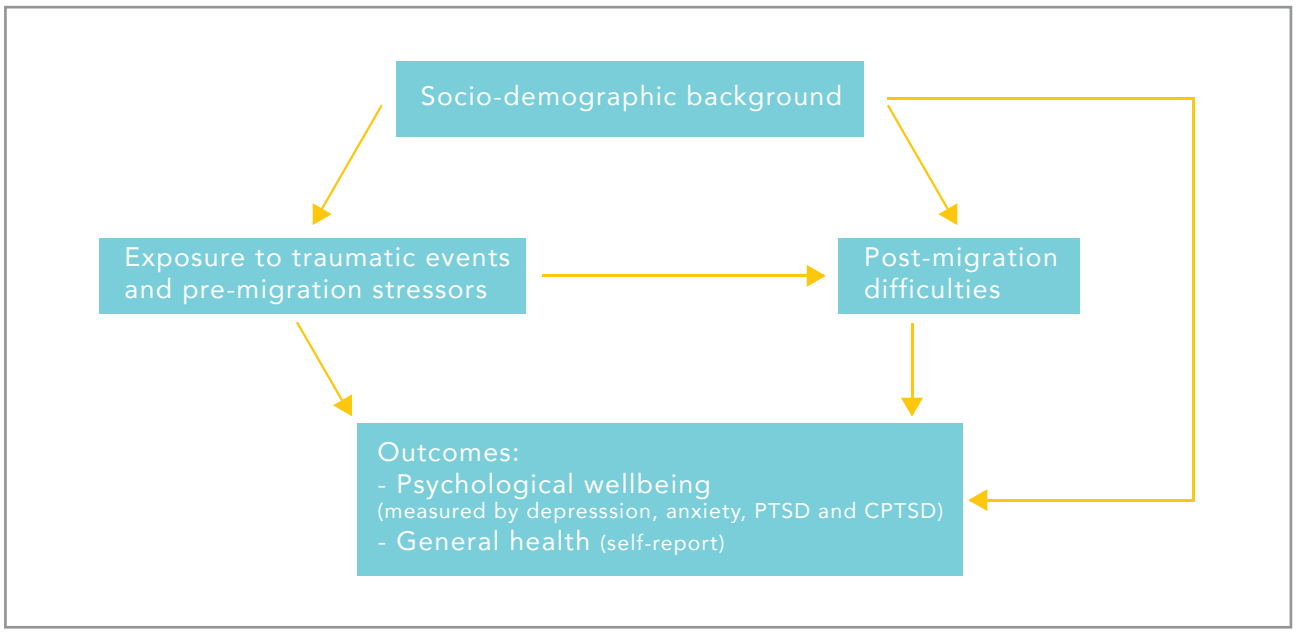
This study was conducted to further understand the impact of the conflict towards migration and the mental health of Patani youths in Malaysia who are either irregular migrants or refugees. It is also hoped to further contribute towards existing literature in terms of evidence and data. It is due to this that the study is designed to address two key objectives:

- To assess psychological distress and perceived health of the Patani youth workforce in Malaysia by looking at the prevalence of the following - Depression, Anxiety, Post Traumatic Stress Disorder (PTSD), Complex Post-Traumatic Stress Disorder (CPTSD).
- To identify factors associated with psychological distress and perceived health of Patani youth workforce in Malaysia

The study will identify the relationships between independent variables of socio-demographic background of the participants, their experience in undergoing detention and torture, and the myriad of traumatic exposures documented in conflict areas that happened before migration, and the challenges they faced after migration. It is unknown whether these variables have an effect on their own to the outcomes that we are interested in, or whether it is in combination of these three main groups of variables.

This study was cross-sectional by design, analysing the relationship of socio-demographics, pre-migration exposure stressors, and post-migration living difficulties to psychological wellbeing and perceived health. This framework is further illustrated in the below diagram.

Diagram 1: Conceptual Framework



METHODOLOGY

A quantitative cross-sectional research design was used in this study. A cross-sectional design is used in order to study the individuals at one point in time in order to determine their psychological distress and trauma symptoms at post-migration (Setia, 2016). The study population of this study would be the Patani youth migrants in Malaysia from the age range of 18 to 35 years old. This study was conducted in Peninsular Malaysia where the project has gathered potential youth migrants from the selected migration areas (Kuala Lumpur, Johor, Kelantan, Penang & Perak).

During the conduct of the landscape analysis, IMAN had experienced difficulties in finding respondents willing to be interviewed. The community seemed reluctant to be interviewed due to possible trust issues. Therefore, for this study, IMAN collaborated with Pertubuhan Cakna Jaringan Warisan Nusantara (PENJANA) for the purpose of recruiting and interviewing the survey participants. PENJANA is a registered non-governmental organisation established by the Patani community in Malaysia with a focus on advocating Patani's history and culture in Malaysia. The organisation was selected due to their extensive connection to the community in various states throughout the Peninsular. IMAN organised several meetings and workshops with enumerators from PENJANA to train them on data collection as well as how to engage with vulnerable groups. IMAN had also established a standard operating procedure (SOP) for engaging with vulnerable groups, especially on what to do if the enumerator feels that the respondent was showing signs of severe trauma.

The design of the survey was purposive sampling, where respondent selection was based on a set of inclusion and exclusion criteria.

Inclusion Criteria:

- Migrated from either one of the provinces in Southern Thailand that is embroiled in the conflict (Yala, Narathiwat, Pattani and Songkhla).
- Aged 18-35 years old.

Exclusion Criteria:

- Formal diagnosis of any mental disorders.
- Unable to read, write and understand Thai, English, or Malay.
- Born in Malaysia.

5.1 Sample Size

A G* Power software that was developed by Faul, et al., 2007, was used to calculate the sample size for this research (Faul, Erdfelder, Lang, & Buchner 2007). F tests were used to consider the sample size according to the objectives in this study, with a selected effect size of 0.15, desired statistical power level at 0.80, and three observed variables (pre-migration trauma, post-migration living difficulties, and psychological distress). By incorporating the above statistical information, the estimated total sample size is 114. However, the study had oversampled the size to 244.

5.2 Research Instruments

Along with sociodemographic items, five certified instruments were used in order to measure the variables which are the Post Migration Living Difficulties Checklist (PMLD), The Hopkins Symptoms Checklist (HCL-25), The Harvard Trauma Questionnaire (HTQ), The International Trauma Questionnaire (ITQ) and The Mental Health Literacy Scale (MHLS).

a. Post-Migration Living Difficulties Scale (PMLD) (Silove, 1988) This scale was used to determine the current stressors and difficulties faced by the Patani youth migrants in Malaysia (Schweitzer, et al., 2006). There are 25 items on this scale and is rated by using a 5-point scale ranging from no problem to a very serious problem. This scale measures the components of health, financial, discrimination, family and relational, and immigration stressors. High scores indicate an increased level of post-migration living difficulties.

b. The Hopkins Symptom Checklist (HCL-25: Mollica et al., 1987). The HCL-25 was used to measure symptoms of depression and anxiety. It consists of 25 items where 10 items will measure anxiety and 15 items will measure depression. There are 25 items in this checklist and it is rated by using a 4-point scale ranging from not at all to extremely.

c. The Harvard Trauma Questionnaires (HTQ: Mollica et al., 1992). The HTQ will be used to assess pre-traumatic events. The questionnaire consists of a yes or no answer with various choices of traumatic events. HTQ was found to have internal reliability of 0.87 (Cronbach's Alpha) (Schweitzer, Melville, Steel & Lacherez, 2006).

d. The International Trauma Questionnaire (ITQ: Cloitre, Roberts, Bisson & Brewin, 2015). The ITQ will be used to measure the symptoms of PTSD and Complex PTSD. This questionnaire consists of 18 items with 9 items to measure the symptoms of PTSD and 9 items for Complex PTSD. Each item is rated by using a 5-point scale ranging from not at all true to extremely true.

e. The Mental Health Literacy and Stigma Questionnaire (MHLSQ). The MHLSQ was adapted from the Young People's Recognition of Mental Disorders and Beliefs about Treatment and Outcome: National Survey (Reavley & Jorm, 2011) and general health status assessment. This questionnaire consists of 9 questions which measures mental health literacy and stigma and the general health status.

All of the instruments were translated using the back translation method where the instruments were translated forward and back in Thai and Malay by professional translators fluent in Thai, Malay and English. First, the instruments were forward-translated by the first group of translators from English to Thai and Malay. These translated instruments were then provided to another group for back translation to English from Thai and Malay. Each group consisted of professional translators who were native Thai or Malay speakers and proficient in the English language. No discrepancies were found between the original text and back translation of the instruments.

DATA ANALYSIS

The data of this study was analysed by using the Statistical Package of Social Science (SPSS) version 26. A descriptive analysis was conducted to describe participants' demographic characteristics, mean and standard deviation of research variables. A Pearson correlational analysis was conducted in order to find the association between the research variables. Linear regression and binary logistics regression was used to identify the contributions of the independent variables on the dependent variables.

6.1 Data Quality

Data cleaning was performed and there were no outliers that were removed as all of the data fulfilled the criteria for Mahalanobis distance. Furthermore, the normality was confirmed using the skewness and kurtosis value obtained from the data within the critical value (skewness ± 3 and kurtosis ± 10) (Kline, 1998), the data can be said to have a normal distribution.

6.2 Participants' Characteristics

The participant's sociodemographic background and migration data are presented in Table 1. About half of the participants were aged between 30-35 years old, with an average age of 32, and the youngest age was 18. About two-thirds were male, and nearly half of the participants had completed education up to secondary level. There was an almost equal proportion that studied until primary level or completed Pondok school. At the time of the interviews, almost all were employed and a vast majority earned an estimated monthly wage that was less than RM2000, with an average monthly wage of RM1000. About a third resided in Klang Valley, with a slightly lesser proportion living in Kelantan, while the rest were almost similarly distributed in Kedah, Terengganu, Johor, Melaka, and Penang. It is noted that Klang Valley included areas in both Selangor and Federal Territories. Slightly more than one-third have been working in Malaysia for more than 10 years, and only about one-tenth migrated before the Tak Bai incident. This means most of the participants migrated to Malaysia post-Tak Bai incident which took place in 2004, with almost 5% of them having spent a significant part of their childhood in Malaysia.

Almost a fifth reported having been arrested in the country of origin, with slightly more than a tenth reporting a history of being tortured. The respondents experienced an average of 4.5 types of trauma events before migration, and about 90% had experienced serious post-migration problems.

Notes from workshop with participants

Table 1: Sociodemographic, Pre- and Post-Migration (N=244)

		Percentage (%)	Mean	Standard Deviation
Age			32	0.727
18-23		14.3		
24-29		34.4		
30-35		51.2		
Gender				0.477
Male		65.2		
Female		34.4		
Education				1.293
Primary		13.5		
Secondary		47.1		
Tertiary		9.8		
Pondok		13.9		
Non-specific/None		15.6		
Employment Status			1.07	0.279
Employed		94.3		
Unemployed		4.9		
Own Business		0.8		0.865
Salary			1000	0.91
Current Location				
Klang Valley		32		
Kedah		12.3		
Pahang		4.2		
Terengganu		10.2		
Kelantan		22.1		
Johor		9.8		
Melaka		9.4		
Duration of stay in Malaysia			3.73	1.234
<1 year		3.2		
1-3 years		16		
4-6 years		23		
7-9 years		18.4		
At least 10 years		38.9		
Migrated post-Tak Bai Migration				
	Yes	88.9		
	No	11.1		
Brought up in Malaysia				
	Yes	4.1		
	No	95.9		
History of arrest				
	Yes	18.9		
	No	81.1		
History if torture				0.314
	Yes	11.1		
	No	88.9		
Experiences of trauma at pre-migration (HTQ)			4.47	6.345
Experiences of serious problems post-migration (PMLD)			28.5	21.4

*mean wage within the range of less than RM2,000.

RESULTS/FINDINGS

Overall, there are three key findings from the study:

Findings #1 – Main Outcomes: Levels of Psychological Distress, Trauma Disorders and General Health

Psychological distress measured by the HCL-25 provided prevalence of two types of mental health problems, which were depression and anxiety. In this study, the prevalence of depression was found to be 13.5%, while anxiety was at 16.80%. Trauma disorders measured by the ITQ provided prevalence for PTSD at 9.4%, and CPTSD was 2%. Participants' subjective measure of their own general health found that 38.5% perceived their health to be not good or poor. Main outcomes of the study are presented in Table.

Table 2: Mean & Standard Deviation of Depression, Anxiety, PTSD, CPTSD and Perception of Health (N=244)

	n	%	Mean	S.D
Depression	33	13.6	1.32	0.3943
Anxiety	41	16.8	1.29	0.36618
PTSD	23	9.4		
CPTSD	5	2.0		
General Health				
Not good	94	38.5	0.61	0.48765
Good	150	61.5		

Findings #2 – History of detention, history of torture, being brought up in Malaysia, and pre- as well as post-migration factors were all associated with the main outcomes (psychological distress, presence of trauma disorders and general health).

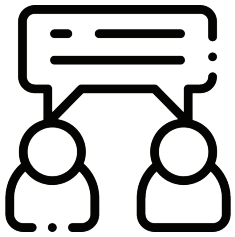
Correlation analyses to look at association between the variables are usually conducted before any predictive analysis. A correlation analyses were conducted and the correlation matrix is presented in Appendix 1. This study's results indicated mostly no association between sociodemographic variables with main outcomes of the study. It was observed that HTQ and PMLD were significantly associated with all the study's main outcomes as presented in Table 3. And only having experienced being brought up in Malaysia, history of torture, and history of detention were identified to be associated with some of the outcomes.

Table 3: Factors Significantly Associated with Main Outcomes

	Main Outcome				
	Dep	Anx	PTSD	CPTSD	GH
HTQ (pre-migration trauma)	√	√	√		√
PMLD (post-migration living difficulties)	√	√	√	√	√
History of torture			√		
History of detention			√		√
Brought up in Malaysia			√		

Legends
Dep: Depression
Anx: Anxiety
PTSD: Post-Traumatic Stress Disorder
CPTSD: Complex Post-Traumatic Stress Disorder
GH: General Health

Findings #3 – Pre-migration trauma and post-migration living difficulties were identified as predictors or risk factors of psychological distress, PTSD and general health.



The multiple linear regression and binary logistics regression analyses was used for modeling and analyzing all the significantly associated variables by describing their relationship with the main outcomes; HTQ and PMLD predicting depression, anxiety, PTSD, CPTSD, and general health. The significant results are as follows:

Table 4: Pre-migration trauma and post-migration living difficulties on psychological distress, PTSD and general health

Pre-migration trauma	Post-migration living difficulties
Pre-migration trauma predicts anxiety. The result shows that the pre-migration traumatic events significantly predicted 32.1% of the variance in anxiety among the Patani youth migrants (R^2 =0.321 F (1, 230) 108.92, p=0.000). Pre-migration trauma predicts depression. The result shows that the pre-migration traumatic events significantly predicted 10.1% of the variance in depression among the Patani youth migrants (R^2 =0.101 F (1, 231) 25.84, p=0.000).	Post-migration living difficulties predict anxiety. The result indicates that the post-migration living difficulties significantly predicted 29.4% of the variance in anxiety among the Patani youth migrants (R^2 =0.294 F (1, 213) 88.56, p=0.000). Post-migration living difficulties predict depression. The result indicates that the post-migration living difficulties significantly predicted 19.3% of the variance in depression among the Patani youth migrants (R^2 =0.193 F (1, 214) 51.31, p=0.000).

Table 5: Pre-migration trauma, post-migration living difficulties and brought up in Malaysia on PTSD and perceived health

Pre-migration trauma predicts PTSD. Those who experienced trauma before migrating to Malaysia are 1.188 times higher to have PTSD compared to those who did not with a 95% CI of 1.071to 1.317.	Post-migration difficulties predict General Health; those who experienced post-migration difficulties were less likely to have good health in general, 0.98 times less likely with a 95% CI of 0.961 to 0.996.	Brought up in Malaysia predicts PTSD; Those who were brought up in Malaysia have an 8.605 times higher likelihood of having PTSD compared to those who did not spend a significant amount of their childhood in Malaysia with a 95% CI of 1.148 to 64.507.

DISCUSSIONS OF FINDINGS

8.1 Sociodemographic Profile, Personal Impact of Conflict And Gender Differences

The Patani youth workforce migration to Malaysia has been a relatively common occurrence due to the nature of political unrest and threat to safety in the Southern Thai region. The prevailing conflict in the country of origin has been a known factor for the youths to flee for safety to Malaysia and this migration is seen as a form of survival instead of just for labour purposes (Klanarong & Ishii, 2016). This flight from conflict may come in waves and tend to be triggered by major events, such as the Tak Bai incident, following which most of the study participants migrated to Malaysia. On an individual basis, major events will include situations that has serious consequences; a significant portion of both male and female Patani youths have history of detention (18.9%), torture (11.1%) and exposure to trauma before migrating (64.7%).

Many seek refuge and labour in Malaysia because the chances of them finding skills training and even employment is higher in Malaysia as compared to other regions in Thailand (Jampaklay, Ford & Chamratrithirong, 2017) but they continue to hold low-paying jobs with significantly lower than national average wage (RM1,727) as reported by the study participants.

An interesting aspect of the female Patani youth migrants in Malaysia, mostly all are independent and not accompanying male chaperones meaning that they had traveled to Malaysia and sought out employment on their own, have higher educational level and have a higher average wage compared to men. This is also contradictory to existing literature where migrant women generally have a lower educational status than men and face more difficulties than men both during the migration journey and later on with their integration into the labour market of their place of arrival (Hillmann and Wastl-Walter 2011).

8.2 Current Situation of Psychological Wellbeing and General Health of the Patani Youth Workforce In Malaysia

The idea of psychological wellbeing in this study was focused on depression, anxiety, and trauma symptoms. By looking at depression and anxiety, we are observing symptoms that are common throughout communities, regardless of their exposures; as we know, community prevalence rates for depression and anxiety ranges from 10% to 30%. The results indicate that the average scores for psychological distress (measured by anxiety and depression) for this population is lower than the clinical range. Based on the mean scores, this study population has a normal range of anxiety and depressive levels, thus it is similar to the general population and other communities (Norris et al., 2011; Kim, 2015; Nickerson et al., 2010). In comparison to other migrant community studies in Malaysia and the region, however, our Patani youths study participants had lower rates of psychological distress. Along with assessing psychological distress via validated instruments, the study also utilized a direct approach to assessing participants' perception of their wellbeing, and here we observe divergent results. While the Hopkins Symptom Checklist indicated normal levels of depression and anxiety experienced by the participants with less than a fifth identified as significantly high levels, their own perception of wellbeing indicated significantly high proportions of depression and anxiety. This could be explained by differing mental health literacy levels and subjective terms in describing their own experiences, which needs to be given consideration.

In relation to the prevalence of trauma, measured by the identification of PTSD and CPTSD, the study found that the 9.2% prevalence of PTSD is higher than the prevalence in the general population but lower in comparison to communities exposed to conflict. A World Health Organization (WHO) study found a lifetime prevalence of PTSD in upper-middle-income and lower-middle-income countries of 2.3 and 2.1% respectively (Koenen et. al., 2017). It is

important to note that PTSD prevalence differs greatly due to the type of trauma individuals or communities experienced. For people exposed to mass conflict and displacement, for example, a meta-analysis of 145 studies of 64,332 refugees and other conflict-affected individuals internationally found a mean PTSD prevalence rate of 30.6% (Steel et. al., 2009).

CPTSD was also measured in this study as an important indicator of psychological wellbeing due to its recognition as a distinct type of trauma to those exposed to prolonged forms of conflict and other stressors, especially from a young age. This describes our study participants and the presence of CPTSD proposes a more severe and impairing disorder. This study's finding of a 2% prevalence rate is reflective of prevalence that ranged from 2.2 to 9.3% reported in a systematic review of CPTSD among refugees and asylum seekers (Umanga de Silva et. al., 2021).

More than a third of the participants reported that their overall or general health is not good; the most frequent types of complaints reported for the past month were depressive symptoms (86.1%), anxiety symptoms (86.9%), irritability (66.4%), lethargy (47.5%), headaches and head pains (42.6%), backaches (36.1%) and flu-like symptoms (30.2%). About half of the participants had access to doctors or formal health care providers. This is in stark contrast to the 92% of the Malaysian population that have access to health services within 3km (Safurah, 2013) of where they live. However, it is equivalent if we were to conduct a geographical comparison, where about 50% of the Malaysian rural population have access to health services within a 5km radius from their residence (Inche Zainal Abidin S, 2014).

In conclusion, psychological wellbeing among the Patani youth migrants is comparable to Malaysians in general but they suffer significantly more from trauma disorders, specifically PTSD and CPTSD. There is a significant proportion of them that have poor health and this is confounded with low accessibility to healthcare services.

8.3 Sociodemographic Factors Were Not Significant Predictors

When looking at the connections between sociodemographic factors and other individual background characteristics of the participants, we can clearly observe the presence of some relationships as presented in Table 3. The results also illustrated that the strength of the relationships among these variables was varied; several were very weak and can be considered negligible. This is different from other findings where it is evident that stable sociodemographic factors identified in many studies such as gender and education were not associated with this study's outcomes. Large scale studies that look at the relationship between gender and psychological distress among humanitarian migrants in Australia for example found that women report significantly higher psychological distress than men (Jarallah and Baxter, 2019), with similar findings in another study focusing on psychological distress experienced among the displaced population in Germany (Walther, Kroge & Tibubos, et. al., 2020). Similarly, studies and reviews on PTSD have shown that women are more at a risk than men (Tolin et. al, 2006). Breslau (2002) showed a higher lifetime prevalence of traumatic events for men than for women while the risk for PTSD following traumatic experience was two-fold higher in women than men, with the two-fold risk for women being attributed to events that involved assaultive violence. These patterns were not observed in our study.

The ones with moderate levels of association (refer to Appendix 1) were pre-migration trauma, post-migration difficulties, history of detention, history of torture, and being brought up in Malaysia. We found that pre-migration traumatic events are moderately associated with the current anxiety symptoms among the Patani youth migrants in Malaysia. This moderately positive correlation indicates that the higher the level of traumatic events experienced by the migrants prior to the migration would associate with the higher level of anxiety that they currently experience in the host country, Malaysia. However, pre-migration traumatic events have a weak relationship with the current depressive symptoms among the Patani youth migrants. This indicates that pre-migration traumatic events experienced by these youths have a smaller

symptoms as compared to anxiety symptoms. The study population tends to manifest their psychological distress through anxiety symptoms such as feeling anxious, palpitation, shortness of breath and other physical manifestations. These findings are parallel with studies showing that these traumatic experiences are usually associated with mental health problems such as anxiety and depression (Birman & Tran, 2008; Keller, et al., 2006).

Post-migration living difficulties are moderately associated with both aspects of psychological distress of the Patani youths including anxiety and depressive symptoms. This indicates that the situational difficulties faced by the youths after the migration to Malaysia such as living adjustment, employment, access to health care, and security aspects are associated with their current psychological distress. These results supported the research findings in the Netherlands, Canada, and Australia which found that post-migration living difficulties were associated with psychological distress such as depression and anxiety (Gerritsen, et al., 2006; Schweitzer, et al., 2006; Simich, et al., 2006).

Several factors were moderately associated with PTSD; brought up in Malaysia, history of detention, history of torture, pre-migration trauma, and post-migration difficulties. The factor with the strongest association with PTSD was pre-migration trauma, which means compared to the other factors, exposure to trauma prior to migration had the biggest impact on the individual that currently has PTSD. For CPTSD, only post-migration living difficulties yielded significant association. These findings of a significant relationship between CPTSD and post-migration living difficulties were similar to the findings of Hecker, Huber, Maier & Maercker (2018).

General health was also associated with pre-migration trauma, post-migration difficulties, and a history of detention. There are not many studies that look at subjective reports of health among migrant and refugee communities, however, it has been identified that members of these communities often suffer from exposed risk to contracting contagious diseases and having lower health quality due to the poor access to healthcare and support (Mucci, Traversini & Giorgi et. al., 2019). This study reflects those findings and goes further into the importance of identifying health quality and conditions of the Southern Thai migrants in Malaysia.

In summarising the relationship between predictor variables and the study's outcomes, we find that this study's most consistent factors were pre-migration trauma and post-migration difficulties. The impact of sociodemographic factors such as gender, less education, lower socio-economic status, and marital status is negligible.

8.4 The impact of pre-migration traumatic events on psychological wellbeing and general health

After identifying the factors that were significantly associated with the outcomes, we conducted further analyses to understand their relationships beyond the idea of mere association. We wanted to see if these factors could actually predict our main outcomes. We found that the associations illustrated in the previous section were further strengthened by the result of the linear regression analyses which indicated that pre-migration traumatic events have a significant influence on the current psychological distress of the Patani youth migrants (anxiety and depressive symptoms). This shows that pre-migration traumatic events that the migrants experienced in the home country have a significant impact and can predict their current psychological distress. These findings are parallel with a study of Vietnamese refugees resettled in Australia showing pre-migration traumatic life events have been an important contributor to depression and anxiety (Steel, Silove, Phan, & Bauman, 2002).

In relation to the trauma, pre-migration traumatic events and history of brought up in Malaysia were maintained as significant risk factors for PTSD among the Patani youth migrants in Malaysia (pre-migration traumatic events in combination with brought up in Malaysia). Thus it can be stated that those with PTSD are more likely to have been exposed to trauma prior to migration and spent a significant part of their early developmental years in Malaysia. This also brings into focus the impact of trauma experienced during childhood and having grown up in adverse situations experienced by many young forced migrants and refugees

(Javanbakht, Stenson, Nugent, Smith, Rosenberg, & Jovanovic, 2021).

8.5 The impact of post-migration living difficulties on psychological wellbeing and general health

Although pre-migration traumatic events were a significant predictor of psychological distress in the present study, post-migration experiences were also of importance in predicting psychological wellbeing and psychological distress. Post-migration living difficulties have a significant impact on the current state of the Patani youths' anxiety and depression. The living difficulties experienced by them after the migration to Malaysia have influenced their current psychological wellbeing. A study by Solove & Ekblad (2002) has shown that post-migration stressors have been known to be one of the determinants of mental health problems.

Another way of looking at this finding is that the current situation in the host country could be maintaining depressive and anxious symptoms. If these symptoms are not attended to timely and appropriately, they could develop into PTSD or CPTSD. And if we place it into the identified context of having low access to care, this trajectory is plausible.

Post-migration living difficulties assessed included poor access to affordable and safe medical, dental, and psychological care, thus it is not surprising that it can significantly predict the level of general health among the Patani youth workforce in Malaysia. Poor health among similar populations due to post-migration difficulties is well documented (Hossain, Baten & Sultana et. al., 2021; Galvan, Lill & Garcini, 2021), which includes long-term impact such as higher risk of developing serious illnesses such as depression and post-traumatic stress disorder (Voorend, Bedi & Fonseca, 2021). In conclusion, post-migration difficulties experienced in Malaysia predict higher symptoms of depression and anxiety and poor general health.

8.6 Understanding Pre-migration Traumatic Events

Based on the results of the linear regression and binary logistics analyses, we can confidently state that the study found two stable risk factors that can predict the level of psychological wellbeing and general health of the Patani youth migrant workforce in Malaysia; pre-migration trauma events (measured by HTQ) and post-migration living difficulties (measured by PMLD). This study found that almost all of the migrants were exposed to trauma, the most frequent type was experiencing physical trauma itself, which includes torture, rape, severe beating, and other severe physical injury. This is followed by the abduction of family members and friends (for example murder, or death due to violence, of spouse or family member, disappearance or kidnapping of spouse or family member or friends). Experiencing lack of basic necessities was the third most frequent type of trauma reported (lack of shelter, food, and water and inability to access healthcare when ill, and confiscation or destruction of personal property), followed by experiencing persecution or coercion (i.e., experiencing threats, forced to betray others or placing them under threat or injury), and lastly witnessing physical trauma of others (ranges from witnessing beatings to torture and murder).

When looking at it from a gender perspective, the study found that males experience significantly higher levels of pre-migration traumatic experience compared to women (Appendix 2). The relationship between trauma exposure and outcome including post-traumatic stress disorder (PTSD) in relation to gender is complex. While there are several theoretical explanations of trauma, that ranges from stress, socio-cultural to cognitive behavioural models, no single theory has been able to explain trauma whether in the general population or refugees' studies. However, studies do show that women are more at a risk than men. The differences for gender have been attributed to different exposure to traumatic events and to different responses to traumatic events. The two-fold risk for women reported by Breslau (2002) was attributed to events that involved the higher number of assaultive violence. In our study, we found that men reported higher number of experienced violence compared to women; men experienced more

physical assault, persecution and coercion, more likely to have been deprived by basic necessities, and to have lost of family and friends through violence and abduction. Our results could be a reflection of the military policy in Southern Thailand that targets male youths which makes the male population more vulnerable to experiencing trauma while young women are more exposed to secondary trauma in the form of cultural assimilation.

8.7 Understanding Post-migration Living Difficulties

A number of post-migration stressors such as lack of access to basic necessities which includes shelter, health care and education for children, discrimination, a general lack of economic opportunity, at risk of exploitation, lack of access to resources, social isolation and lack of integration, have been shown to have strong negative direct effects on mental health and wellbeing (Kirmayer et al., 2010). Moreover, a longitudinal study on refugees also suggests that the effect of these stressors has different effects and trajectories for males and females (Stempel et. al., 2016; Wu et.al., 2021). Our study found male Patani migrant youths had significantly poorer access to health and mental health care, poorer access to welfare and other supportive services, fewer work opportunities and poorer working conditions, suffered more from loneliness and isolation, and experienced more problems in relation to immigration services (Appendix 1). However, both male and female youth migrants experienced similar difficulties related to communication, discrimination, acquiring permission to work, worries about family left behind, and challenges in adjusting to the host country. Overall, female youth migrants seem to experience fewer post-migration difficulties, but the reason for this is both complex and unclear. Other studies looking at gender differences of post-migration distress were conducted in high-income host distress were conducted in high-income host countries with markedly different gender ideologies and roles of those who migrated. Gender-specific effects of resettlement are focused on the impact of acculturation, and in general, traditional women and egalitarian men experience less distress (Stempel et. al. 2016). Thus, Malaysia and Southern Thailand, with familiar if not similar gender roles, culture, and language, seem to provide female migrants more room to maneuver the complications of resettling and adapting.

Dr. Mahadir Ahmad Q&A session with participants

CONCLUSION OF MAJOR FINDINGS

To conclude the analysis on findings, it can be summarised into five key points:

1. The study has documented elevated rates of mental health problems in the migrant populations, and the links between psychological wellbeing and ill health and pre- and post-migration potentially traumatic experiences is established.

2. Contrary to other studies, sociodemographic variables did not play a role in predicting psychological wellbeing and general health of Patani youth migrant workers in Malaysia. In fact, it is the combination of pre-migration push factors associated with the conflict, and post-migration issues that rendered adaptation and current living experiences in Malaysia challenging, these were identified as risk factors.

3. The findings indicate that with the high degrees of trauma and psychological distress present in the population, the use of detention and the experience of post-migration difficulties would be cruel and retraumatizing.

4. Despite a high level of trauma exposure experienced by both men and women, most exhibit psychological resilience to events of the past and seek support and resources to build a new future. It is noted that women experienced less difficulties after migrating to Malaysia and can adapt better; this could be a premise for women to lead in effort to integrate with local communities and as intermediaries to influence better access to the welfare services, healthcare and fairer working conditions.

5. Contrary to previous research findings, our study found that males experience significantly higher levels of pre-migration traumatic experience compared to women.

LIMITATIONS OF THE STUDY

Due to the nature of the population being studied, there were two key limitations. Firstly, it was difficult to conduct random sampling in absence of any kind of database on Patani migrant workers in general and Patani irregular workers in specific. Second, the study was unable to assess personal and family psychiatric history of the participants, this information could have further assisted in getting a more in-depth understanding of the physical and mental health quality of the individual.

Dr. Irma interviewing a participant with an interpretor

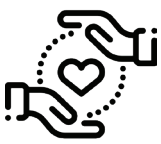
RECOMMENDATIONS

The findings of this study have highlighted the mental health and general wellbeing challenges faced by the Patani youth migrant community in Malaysia. It is a fact that they are experiencing depression, anxiety, and PTSD even before migrating to Malaysia, which was further compounded by post-migration experiences. According to existing literature, we know that poor mental health not only affects a person's ability to live a fulfilling life and carry on with their school, work, or familial responsibilities; it can also lead to physical and social problems with serious impacts to not only the individual but the community if left untreated. Through the study, we also found evidence of the Patani community's ability to be resilient and how this should be further strengthened. Therefore, this study's recommendations cover both Patani community in Malaysia and Southern Thailand with the following:

11.1 Policy

1. Access to Healthcare Facility Regardless of Immigration Status

It is in the interest of not only the migrants, but also the country that hosts them, that opportunities for health outbreaks are kept to a bare minimum, and appropriate access for both mental and physical health services is guaranteed. Alongside the humanitarian aspect, this has profound public health and economic benefits, where steps can be planned to ensure protection of health and safety of the local community and host country. Malaysia already has a policy in place that allows undocumented, stateless and refugees to seek treatment in public health facilities but the significant difference in cost being charged to non-Malaysians and stigma associated discourages people to acces them.



2. To Further Support The Peace Process with The Objective of Achieving a Sustainable Peace Agreement

The overall mental health of the population is strongly correlated to the conflict occurring in Southern Thailand. Their life decisions which include migration is a result of the violence, so the need to address the conflict is critical to help in addressing some of their mental health issues both migrant population as well as those living in Southern Thailand. For example, a recent study of mental health inequalities in Meta, Colombia showed a reduction by almost half from 2014 to 2018, after the signing of the Peace Agreement in 2016. Therefore, as a start, to make the current peace dialogue process more inclusive - to include a role for civil society especially in bringing forward the aspiration of the community to the government and rebel groups. Further studies should be conducted to look at how mental health and wellbeing could be further improved as a result of a peace accord.

3. A Malaysian Asylum policy

People fleeing persecution and harm from their country of origin should be protected. By having an asylum policy - it would provide the most basic protection to a human being which is the right to life. Accepting refugees and/or asylum seekers is also a win for the receiving country and the communities that host them. The Malaysian government has recently announced its decision to establish its own registration system called Tracking Refugees Information System (TRIS), this system should be more than just a tracking system but instead assist in providing basic integration assistance which includes access to skills training for employment, access to public education and public healthcare at affordable rates. This would allow refugees and asylum seekers to be not only independent but contribute to the host country without fear of persecution.

11.2 Programme

1. Community-based Psychosocial Services

There is an opportunity to develop community-based psychosocial services based on resiliency building, as most of the psychological distress identified are at a manageable level, similar to local communities. This is despite the significant amount of trauma events at pre- and post-migration. Community-based support can easily be developed by upscaling community members and community social workers and other existing CSOs already actively involved in assisting Patani migrant communities. However, specialized mental health care is needed for those suffering from PTSD and CPTSD, and a feasible and sustainable approach is needed for this. Considering the feasibility and sustainability factors into the future, community-based psychosocial support would improve the effectiveness and reduce the managerial costs associated with the program. Therefore, it is proposed for:

a. Training and capacity building of community-based providers on Mental Health assistance both in Malaysia and in Southern Thailand.

b. Mental health assistance that is targeted. As we now know, men and women experience mental health differently and programmes would be best designed to address their needs.

c. Set-up of a Mental Health intervention centre for more serious problems within the border state of Kelantan to service the Patani community both across the border in Malaysia as well as an alternative centre for Patani community in the South to access. Due to the high level of distrust towards Bangkok and Thai language as a barrier, a centre in Malaysia is an ideal alternative.

2. To Include The Patani Community Fleeing The Conflict as Asylum Seekers

While a majority of the migrant community are more qualified to be classified as economic migrants, there is still a sizable number of Patani youth migrants whose experiences correlate with those of an asylum seeker or refugee. Pre-migration trauma and experience appear to satisfy the legal criteria for asylum yet there are no records of any Patani having requested asylum in Malaysia except for the 131 detained in Terengganu in 2005 but even they were not provided asylum status. Examining how the experiences of migrants correspond with the requirements for asylum status can powerfully inform public discourse and policy. Especially since the Patani community have integrated well within the local population and are seen as positive contributors towards the local economy and culture. For example, the Tom Yam Restaurant scene clearly shows how they have integrated when given a chance.

3. Women Community Leaders

As mentioned, Patani women have been able to integrate better in Malaysia and the number of Patani women entrepreneurs emerging is also positive. This has a direct impact towards immediate family members and village community back home in the South as well as providing employment opportunities to new migrants coming into Malaysia. This gives these women a unique position of leadership within their community. By tapping them as informal leaders, this can help to further empower the community socially and politically.



11.3 Research

1. Gender-focused Studies

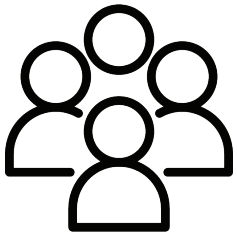
The results have shown that there is a gender difference when it comes to resilience factors among Patani youths. In contradiction to many studies, female migrants from Patani are not more vulnerable than their male counterparts, despite the fact they experience similar traumas, including physical violations, albeit at a lower rate than men. Further studies with a gender-focused approach are warranted to identify strengths and resilience of different gender groups, this will yield information of the different skill sets needed.

2. Children Well Being

It has been 18 years since the Tak Bai massacre and Krue Se Mosque stand-off. Many of those who were youths during that time now have families of their own. Children exposed to daily violence and trauma as a result of the conflict will be exposed to long-term mental health issues. Patani children in Malaysia, whose parents fled the South and are undocumented here, not only experience generational trauma from their parents but being an undocumented themselves leaves them with little hope or future yet there is currently no data on their wellbeing. This will contribute to the design of an early intervention programme that is critical and has significant potential on Malaysian human capital.

3. Socio-Economic Study to look at the Impact of Patani Migrant Community Towards Malaysia

To look at how this community has benefited Malaysia socially and economically. As Malaysia enters into an aging population and experiencing labour shortage, this is an untapped resource. To add, as the irregular migrant/refugee/asylum seeker population is increasing, to leave it unaddressed will be detrimental and a waste of resources.



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APPENDIX

Table: Correlational analyses to examine the relationship between socio-demographic, pre-migration and post-migration variables and psychological distress, trauma disorders and general health

Correlation Matrix of Research Variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Age	-																		
Gender	-.106	-																	
Education	.047	-.055	-																
Employment Status	.138*	-.049	.071	-															
Type of Employment	-.061	.000	-.212**	-.530**	-														
Salary Range	.085	.090	.068	-.096	-.277**	-													
Location	.128*	-.135*	-.044	.170**	.042	-.165	-												
DSM	.360**	-.042	-.137*	.028	.058	.086	.107	-											
TBM	-.108**	.093	-.057	.083	-.048	-.098	.069	-.353**	-										
BIM	.041	-.004	.124	-.026	.041	.041	.011	-.006	-.079	-									
BUIM	.037	.093	.058	.174**	-.010	-.084	.140*	.113	-.059	.352**	-								
HT	.201**	-.004	.006	.105	-.061	-.084	.096	.056	-.084	.079	.059	-							
HD	.189**	.066	-.064	.150*	-.042	-.112	.211**	.089	-.030	.136*	.165**	.632**	-						
PMLD	.143**	-.230*	.142*	.306**	-.101	-.346**	.444**	-.029	.082	.104	.161*	.346**	.334**	-					
HTQ	.154**	-.242**	-.068	.140*	-.029	-.051	.322**	.063	.087	.075	.066	.568	.433**	.585**	-				
HSCL A	.047	-.264**	-.077	.082	.041	-.196**	.379**	.049	.052	.184**	.169**	.282**	.297**	.542**	.567**	-			
HSCL D	.025	-.252**	-.089	.103	-.007	-.173	.336**	.020	.034	.055	.074	.151*	.183**	.440**	.317**	.772**	-		
PTSD	.088	-.058	.017	.075	.002	-.099	.174**	.025	.069	.091	.287**	.199**	.204**	.358**	.436**	.470**	.431**	-	
CPTSD	.084	-.025	.198**	-.034	.053	-.059	.145*	.032	-.041	-.246**	.116	.041	.078	.192**	.084	.376**	.261**	.349**	-

DSM - DURATION STAY IN MALAYSIA
TBM - TAK BAI MIGRATION
BIM - BORN IN MALAYSIA
BUIM - BROUGHT UP IN MALAYSIA
HT - HISTORY OF TORTURE
HD - HISTORY OF DETAINED
PMLD - POST MIGRATION LIVING DIFFICULTIES
HTQ - PREMIGRATION TRAUMA
HSCL A - HOPKINS SYMTOMS CHECKLIST ANXIETY
HSCL D - HOPKINS SYMTOMS CHECKLIST DEPRESSION

Gender Analysis of Risk Factors for Psychological Distress, Trauma and General Health

Table 1: Exposure to Trauma at Pre-Migration by subtypes (N=244) according to gender

		Gender							
	HTQ Subtypes	**Male**			**Female**				
		n	Mean	SD	n	Mean	SD	t	Sig.
1.	Physical trauma to others	158	0.19	0.61	84	0.14	0.47	0.62	.538
2.	Physical trauma to self	156	2.78	3.45	83	1.16	2.35	4.29	.000
3.	Lack of basic necessities	158	0.75	1.04	84	0.31	0.66	3.99	.000
4.	Abduction or loss of a family member or friend	158	1.15	1.55	82	0.67	1.65	2.20	.029
5.	Persecution or coercion	158	0.59	0.95	82	0.13	0.51	4.87	.000

Table 2: Prevalence of Depression, Anxiety, PTSD, CPTSD and Perception of Health (N=244)

	n	%
Depression		
with	33	13.5
without	211	86.5
Anxiety		
with	41	16.8
without	203	83.2
PTSD		
with	23	9.4
without	221	90.6
CPTSD		
with	5	2.0
without	239	98
Perceived Health		
Not good	94	38.5
Good	150	61.5

Table: Post-migration Living Difficulties Items according to gender (N=244)

Item on the PMLD		Gender						t	Sig.
		Male			Female				
		n	Mean	S.D.	n	Mean	S.D.		
1.	Worries about not getting treatment for health problems	159	1.69	1.17	84	1.18	1.11	3.27	.001
2.	Poor access to emergency medical care	159	1.92	1.268	84	1.42	1.30	2.91	.004
3.	Poor access to long term medical care (family doctor, primary care physician)	158	1.89	1.28	84	1.39	1.38	2.82	.005
4.	Poor access to dental care	159	1.43	1.34	84	0.82	0.96	4.06	.000
5.	Poor access to counseling services	158	1.75	1.36	84	0.99	1.01	4.91	.000
6.	Little government help with welfare (unemployment benefits, financial help)	157	2.08	1.59	84	1.43	1.46	3.14	.002
7.	Little help with welfare from charities (social service, eg., Red Cross)	159	1.95	1.53	84	1.11	1.18	4.75	.000
8.	Delays in processing refugee/ immigrant applications	157	2.18	1.70	82	1.46	1.57	3.28	.001
9.	Communication difficulties/ language difficulties	158	0.69	0.923	84	0.63	0.757	0.50	.616
10.	Discrimination	151	0.88	1.00	79	0.73	0.957	1.01	.285
11.	Being unable to find work	158	0.89	1.19	83	0.55	0.91	2.46	.015
12.	Bad working conditions	157	0.75	1.21	83	0.40	0.72	2.85	.005
13.	Poverty (not having enough money for basic needs - food, clothing, shelter)	159	0.86	1.26	84	0.37	0.74	3.83	.000
14.	No permission to work	158	1.33	1.70	84	0.98	1.49	1.67	.096
15.	Separation from family	159	1.60	1.53	84	1.19	1.26	2.26	.025
16.	Worries about family back home	158	1.99	1.42	84	1.68	1.27	1.67	.097
17.	Unable to return home to family in an emergency	159	2.03	1.64	83	1.28	1.52	3.48	.001
18.	Loneliness and boredom	157	1.20	1.40	84	0.77	0.92	2.82	.005
19.	Isolation (loneliness, being or feeling alone)	159	0.81	1.10	84	0.54	0.77	2.23	.027
20.	Poor access to traditional foods	159	0.62	1.06	84	0.27	0.65	3.18	.002
21.	Interviews by immigration	159	1.68	1.61	84	0.92	1.22	4.12	.000
22.	Conflict with immigration officials	159	1.15	1.59	84	0.61	1.20	2.99	.003
23.	Fears of being sent home	159	1.58	1.65	83	0.70	1.05	5.10	.000
24.	Being unable to practis you religion	159	0.19	0.57	84	0.21	0.70	-0.23	.816
25.	Difficulty adjusting to the weather / climate	159	0.23	0.58	84	0.18	0.42	0.76	.446
Total PMLD		**141**	**32.66**	**22.98**	**75**	**20.59**	**15.62**	**4.56**	**.000**

Demographics

1. **Name:** _____
2. **Age:** _____
3. **Gender:** Male ____ Female ____
4. **Education:**

   _____
5. **Employment:** Yes____ No____
6. **Current Residence:**

   _____
7. **When did you first enter Malaysia?**

   _____
8. **Were you born in Malaysia?** Yes ____ No____
9. **Were you raised in Malaysia?** Yes ____ No ____
10. **History of detention:** Yes ____ No____
11. **History of torture:** Yes____ No____

Harvard Trauma Questionnaire (HTQ): Traumatic Events

We would like to ask you about your past experiences prior migrating to Malaysia. All answers to the questions will be kept confidential. Please indicate whether you have experienced any of the following events by marking the box next to each question with YES or NO.

No	Traumatic Events	YES	NO
1.	Lack of shelter		
2.	Lack of food or water		
3.	Ill health without excess to medical care		
4.	Confiscation or destruction of personal property		
5.	Combat situation (e.g., shelling and grenade attacks)		
6.	Forced evacuation under dangerous conditions		
7.	Beating to the body		
8.	Rape		
9.	Other types of sexual abuse or sexual humiliation		
10.	Knifing or axing		
11.	Torture, mentally and physically		
12.	Serious physical injury from combat situation or landmine		
13.	Imprisonment		
14.	Forced labor (like animal or slave)		
15.	Extortion or robbery		
16.	Brainwashing		
17.	Forced to hide		
18.	Kidnapped		
19.	Other forced separation from family members		
20.	Forced to find and bury bodies		
21.	Enforced isolation from others		
22.	Someone was forced to betray you and place you at risk of death or injury		
23.	Prevented from burying someone		
24.	Forced to desecrate or destroy the bodies or graves of deceased persons		
25.	Forced to physically harm family member or friend		
26.	Forced to physically harm someone who is not family or friend		
27.	Forced to destroy someone's else's property or possessions		
28.	Forced to betray family member, or friends placing them at risk of death or injury		
29.	Forced to betray someone who is not family or friend placing them at risk of death or injury		
30.	Murder, or death due to violence, of spouse		
31.	Murder, or death due to violence, of child		
32.	Murder, or death due to violence, of other family member or friend		
33.	Disappearance or kidnapping of spouse		
34.	Disappearance or kidnapping of child		
35.	Disappearance or kidnapping of other family member or friend		
36.	Serious physical injury of family member or friend due to combat situation or landmine		
37.	Witness beatings to head or body		
38.	Witness torture		
39.	Witness killing/murder		
40.	Witness rape or sexual abuse		
41.	Another situation that was very frightening or in which you felt your life was in danger. Specify:		

Post-Migration Living Difficulties Scale (PMLD)

We would like to ask you about some difficulties you may have experienced since migrating to Malaysia. Please answer the questions using the following scale, and choose the response which is most appropriate for you.

Scale	0	1	2	3	4
Response	No Problem	A little Problem	Somewhat a Problem	A fairly big problem	Serious Problem

No.	Post Migration Living Difficulties	0	1	2	3	4
1.	Worries about not getting treatment for health problems					
2.	Poor access to emergency medical care					
3.	Poor access to long term medical care (family doctor, primary care physician)					
4.	Poor access to dental care					
5.	Poor access to counseling services					
6.	Little government help with welfare (unemployment benefits, financial help)					
7.	Little help with welfare from charities (social services, eg., Red Cross)					
8.	Delays in processing refugee/ immigrant applications					
9.	Communication difficulties/ language difficulties					
10.	Discrimination					
11.	Being unable to find work					
12.	Bad working conditions					
13.	Poverty (not having enough money for basic needs – food, clothing, shelter)					
14.	No permission to work					
15.	Separation from family					
16.	Worries about family back home					
17.	Unable to return home to family in an emergency					
18.	Loneliness and boredom					
19.	Isolation (loneliness, being or feeling alone)					
20.	Poor access to traditional foods					
21.	Interviews by immigration					
22.	Conflict with immigration officials					
23.	Fears of being sent home					
24.	Being unable to practice your religion					
25.	Difficulty adjusting to the weather/ climate					

3

HOPKINS SYMPTOM CHECKLIST-25

Listed below are symptoms or problems that people sometimes have. Please read each one carefully and describe how much the symptoms bothered you or distressed you in the last week, including today. Place a check in the appropriate column.

International Trauma Questionnaire

Instructions: Please identify the experience that troubles you most and answer the question in relation to this experience.

Brief description of the experience _____

When did the experience occur? (circle one)

A. less than 6 months ago
B. 6 to 12 months ago
C. 1 to 5 years ago
D. 5 to 10 years ago
E. 10 to 20 years ago
F. more than 20 years ago

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?	0	1	2	3	4
P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	0	1	2	3	4
P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	0	1	2	3	4

4

P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	0	1	2	3	4
P5. Being "super-alert", watchful, or on guard?	0	1	2	3	4
P6. Feeling jumpy or easily startled?	0	1	2	3	4

In the past month have the above problems:

P7. Affected your relationships or social life?	0	1	2	3	4
P8. Affected your work or ability to work?	0	1	2	3	4
P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you.

How true is this of you?	***Not at all***	***A little bit***	***Moderately***	***Quite a bit***	***Extremely***
C1. When I am upset, it takes me a long time to calm down.	0	1	2	3	4
C2. I feel numb or emotionally shut down.	0	1	2	3	4
C3. I feel like a failure.	0	1	2	3	4
C4. I feel worthless.	0	1	2	3	4

C5. I feel distant or cut off from people.	0	1	2	3	4
C6. I find it hard to stay emotionally close to people.	0	1	2	3	4

In the past month, have the above problems in emotions, in beliefs about yourself and in relationships:

C7. Created concern or distress about your relationships or social life?	0	1	2	3	4
C8. Affected your work or ability to work?	0	1	2	3	4
C9. Affected any other important parts of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

MENTAL HEALTH LITERACY AND STIGMA QUESTIONNAIRE

The purpose of these questions is to get an understanding of your knowledge and opinion of various aspects of mental health. When responding, we are interested in your degree of knowledge and understanding.

SCENARIO

J is 30 years old. J has been feeling unusually sad and miserable for the last few weeks. Even though J is tired all the time, J has trouble sleeping nearly every night. J does not feel like eating and has lost weight. J cannot focus on the work at hand and puts off making decisions. Even day-to-day tasks seem too much for J. This has come to the attention of J's boss, who is concerned about J's lowered productivity.

SECTION A: The purpose of these questions is to measure your knowledge and understanding of mental health.

Q1. In your opinion, what, if anything, would you say is wrong with J? You may choose (✓) more than one response from the following:

☐ Depression ☐ Nervous breakdown
☐ Schizophrenia ☐ Paranoid schizophrenia
☐ Mental illness ☐ Psychological/mental/emotional problems ☐ Stress ☐ Has a problem
☐ Cancer ☐ Nothing
☐ Don't know ☐ Others _____

Q2. How do you think J could be best helped? Choose (✓) only ONE (1) of the following:

☐ Talk over with friends/family ☐ See a doctor (GP)
☐ See a psychiatrist ☐ See a psychologist
☐ Take medication or have counselling ☐ See a counsellor
☐ J must first recognize the problem ☐ Others _____
☐ Don't know

Q3. There are a number of different people, some professional, some not, who could possibly help J. For each of the following, are the people likely to be helpful, harmful, or neither for J?

You can choose (✓) your response based on the following:

1	2	3	4	5
Helpful	Neither	Harmful	*Depends	Don't know

*Include explanation for choice 4 in the 'Remark' column.

	1	2	3	*4	5	*Remark
a) A typical family GP or doctor						
b) A typical pharmacist						
c) A counsellor						
d) Social worker						
e) Case officer						
f) Telephone counselling service/ Helpline						
g) A psychiatrist						
h) A psychologist						
i) Close family member						
j) Close friends						

k) A naturopath or herbalist						
l) Religion's healer/Imam/Ustaz/Priest						
m) J deals with the problem on their own						

SECTION B: The purpose of these questions is to measure your knowledge and understanding of mental health services and treatment options.

Q4. There are different kinds of help and treatment which could be offered by some of the people just mentioned. Do you think the following different MEDICINES are likely to be helpful, harmful or neither to J?

You can choose (✓) your response based on the following:

1	2	3	4	5
Helpful	Neither	Harmful	*Depends	Don't know

*Include explanation for choice 4 in the 'Remark' column.

	1	2	3	*4	5	*Remark
a) Vitamins and minerals, tonics, or herbal medicines						
b) Pain relievers, such as aspirin, codeine or panadol						
c) Anti-depressants						
d) Antibiotics						
e) Sleeping pills						
f) Anti-psychotics						
g) Tranquillisers such as valium						

Q5. There are different kinds of help and treatment which could be offered by some of the people just mentioned. Do you think the following TREATMENTS are likely to be helpful, harmful or neither to J?

You can choose (✓) your response based on the following:

1	2	3	4	5
Helpful	Neither	Harmful	*Depends	Don't know

*Include explanation for choice 4 in the 'Remark' column.

	1	2	3	*4	5	*Remark
a) Becoming more active physically, such as playing more sport, or doing more walking or gardening						
b) Reading about people with similar problems and how they have dealt with them						
c) Getting out and about more						
d) Attending courses on relaxation, stress management, meditation, or yoga						
e) Cutting out alcohol/cigarette altogether						
f) Psychotherapy						
g) Cognitive Behavior Therapy						
h) Hypnosis						

i) Being admitted to a psychiatry ward or a hospital						
j) Undergoing electro-convulsive therapy (ECT)?						
k) Having an occasional alcoholic drink/cigarette to relax						
l) Going on a special diet or avoiding certain foods						

Q6. Do you think the following would be helpful, harmful or neither for J?

You can choose (✓) your response based on the following:

1	2	3	4	5
Helpful	Neither	Harmful	*Depends	Don't know

*Include explanation for choice 4 in the 'Remark' column.

	1	2	3	*4	5	*Remark
a) Consulting a web site that gives information about the problem						
b) Consulting an expert using email or the web about the problem						
c) Consulting a book that gives information about the problem						
d) Receiving information about the problem from a health educator						
e) Using a wellness app						

SECTION C: The purpose of these questions is to measure your understanding of mental health stigma.

Q7. What would be the likely result if J had the sort of professional help you think is most appropriate? Choose (✓) only ONE (1) of the following:

☐ Full recovery with no further problems
☐ Full recovery, but problems would probably re-occur
☐ Partial recovery
☐ Partial recovery, but problems would probably re-occur
☐ No improvement
☐ Get worse
☐ Don't know

Q8. What would be the likely result if J did NOT have any professional help? Choose (✓) only ONE (1) of the following:

☐ Full recovery with no further problems
☐ Full recovery, but problems would probably re-occur
☐ Partial recovery
☐ Partial recovery, but problems would probably re-occur
☐ No improvement
☐ Get worse
☐ Don't know

Q9. Suppose that J had the sort of help that you think is most appropriate for the problem. In the long term, compared to other people in the community, and AFTER getting help, how likely are they to:

You can choose (✓) your response based on the following:

1	2	3	4	5
More likely	Just as likely	Less Likely	*Depends	Don't know

*Include explanation for choice 4 in the 'Remark' column.

	1	2	3	*4	5	*Remark
a) Be violent						
b) Drink too much alcohol						
c) Take illegal drugs						
d) Have poor friendships						
e) Attempt suicide						
f) Be understanding of other people's feelings						
g) Have a good marriage						
h) Be a caring parent						
i) Be a productive worker						
j) Be creative or artistic						

Q10. Do you think that J would be discriminated against by others in the community, if they knew about the problems they have had? Choose (✓) only ONE (1) of the following:

☐ Yes ☐ No ☐ Don't know

Q11. The next few questions contain statements about J's problems. Please indicate how strongly YOU PERSONALLY agree or disagree with each statement.

You can choose (✓) your response based on the following:

1	2	3	4	5	6	7
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	*Depends	Don't know

*Include explanation for choice 6 in the 'Remark' column.

	1	2	3	4	5	*6	7	*Remark
a) People with a problem like J's could snap out of it if they wanted								
b) A problem like J's is a sign of personal weakness								
c) J's problem is not a real medical illness								
d) People with a problem like J's are dangerous to others								
e) It is best to avoid people with a problem like J's so that you don't develop this problem								
f) People with a problem like J's are unpredictable								
g) If I had a problem like J's I would not tell anyone								
h) I would not employ someone if I knew i) they had a problem like J's								
j) I would not vote for a politician if I knew they had suffered a problem like J's								

Q12. The next few questions would like you to tell us what you think MOST OTHER PEOPLE believe. Please indicate how strongly you agree or disagree with the following statements.

You can choose (✓) your response based on the following:

1	2	3	4	5	6	7
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	*Depends*	Don't know

**Include explanation for choice 6 in the 'Remark' column.*

	1	2	3	4	5	*6	7	*Remark
a) Most other people believe that people with a problem like J's could snap out of it if they wanted								
b) Most people believe that a problem like J's is a sign of personal weakness								
c) Most people believe that J's problem is not a real medical illness								
d) Most people believe that people with a problem like J's are dangerous to others								
e) Most people believe that it is best to avoid people with a problem like J's so that you don't develop this problem								
f) Most people believe that people with a problem like J's are unpredictable								
g) If I had a problem like J's most people would not tell anyone								
h) Most people would not employ someone they knew had a problem like J's								
i) Most people would not vote for a politician they knew had suffered a problem like J's								

Q13. The next few questions ask about how willing you would be to have contact with someone like J.

You can choose (✓) your response based on the following:

1	2	3	4	5
Definitely willing	Probably willing	Probably unwilling	Definitely unwilling	Don't know

	1	2	3	4	5
a) To move next door to J					
b) To spend an evening socializing with J					
c) Make friends with J					
d) Start working closely with J on a job					
e) To have J marry into your family					

SECTION D: There are many people in the community who suffer from problems like J's. The next question is about possible causes of this sort of problem developing in J.

Q14. How likely do you think each of the following is to be a reason for such problems?

You can choose (✓) your response based on the following:

1	2	3	4	5
Very Likely	Likely	Not Likely	*Depends*	Don't know

**Include explanation for choice 4 in the 'Remark' column.*

	1	2	3	*4	5	*Remark
a) A virus or other infection						
b) Allergy or reaction						
c) Day-to-day problems such as stress, family arguments, difficulties at work or financial difficulties						
d) Recent death of a close friend or relative						
e) Traumatic event such as flood incidents, bombings, physical/sexual assault, detained by authorities.						
f) Problems from childhood such as being badly treated or abused, witnessing deaths or injuries, losing one or both parents when young, or coming from a broken home						
g) Inherited or genetic						
h) Chemical imbalance in the brain						
i) Being a nervous person						
j) Weakness of character						

SECTION E: The next few questions are about your health.

Q15. In general, would you say that your health is excellent, good, fair or poor?

Choose (✓) only ONE (1) of the following

☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Don't know

Q16. In the last month, have you suffered from any of the following?

You can choose (✓) your response based on the following:

1	2	3
Yes	No	Don't Know

	1	2	3
a) Colds			
b) Sore throats			
c) Headaches			
d) Dizziness			
e) Palpitations			
f) Breathlessness			
g) Backache			
h) Flu			
i) Anxiety			
j) Depression			
k) Tiredness			
l) Irritability			
m) Nervousness			

Q17. Do you currently have access to a doctor/GP?

☐ Yes ☐ No

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