An exploration of 'Alcohol and Other Drugs and Mental Health' counselling with migrant Iranian men in Australia

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Statement of originality

This is to certify that to the best of my knowledge; the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

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Keywords

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Abstract

Background

Substance use and mental health issues are significant contributors to disability on a global scale. Immigrants are particularly vulnerable to these challenges due to a range of pre- and post-migration factors. They face an increased risk of experiencing psychological distress, anxiety, depression, and post-traumatic stress disorder (PTSD), often resorting to alcohol and other drugs as a means of coping. Additionally, certain immigrant groups are less likely to use or seek mental health and addiction services compared to the general population. Over the past several decades, Australia has witnessed an unprecedented influx of immigrants from various countries, including Iran, driven by political conflicts and poverty within those nations.

Although the proportion of Iranian migrants in Australia is relatively small compared to the general Australian population, forced Iranian migrant men warrant special attention due to the barriers they encounter in seeking and accessing mental health services. These barriers arise from cultural differences between Iran and Australia, as well as communication issues and the stigma surrounding mental health problems. Living with unresolved mental health issues can adversely affect immigrants' physical health and influence their thoughts, feelings, and behaviour. While it has been suggested that bilingual counsellors be made available to address the mental health needs of Iranian immigrants, this group disproportionately experiences mental health and addiction issues compared to the wider Australian population. Discrimination may exacerbate this disparity, which partly stems from a lack of bilingual counsellors, particularly female practitioners, who can understand and communicate in Persian.

There is a notable gap in knowledge concerning the consumption of alcohol and other drugs (AOD), the mental health challenges encountered by forced Iranian migrant men in Australia, and the mental health counselling services available to them. This situation illustrates the importance of further understanding in this area. Moreover, there is a need for insights into the experiences of mental health and AOD addiction counsellors to improve access to and engagement with treatment and addiction services in Australia.

Aim of the study

The primary aim of this study was to explore the relationship between migration, mental health, and alcohol and other drug (AOD) consumption among Iranian men who are forced migrants. Additionally, it sought to investigate their attitudes towards seeking help and to evaluate the effectiveness of the mental health and AOD services and support available to them. Furthermore, the study aimed to provide guidance for bilingual counsellors in addressing AOD use and mental health issues among Iranian migrants in Australia by employing an autoethnography-based approach.

Study design

I conducted the study in two phases. The first phase was a qualitative project informed by phenomenology, which employed a collaborative approach. My thesis was grounded in social constructionist and feminist theoretical frameworks. This research comprised two main phases. The first phase involved conducting 30 in-depth focus group interviews with forced migrant Iranian men who had experienced mental health issues, struggled with alcohol and other drug (AOD) addiction, and had received treatment services at the Drug and Alcohol Multicultural Education Centre (DAMEC).The second phase comprised an autoethnographic study in which I

drew upon my memories to recount my experiences as an Iranian migrant and a female counsellor who provided counselling services to culturally and linguistically diverse communities, including Iranian migrants in Australia, who required assistance with AOD issues. The autoethnography was enriched by reflecting on the researcher's reflexive experiences, which added depth to the research findings. Furthermore, I supported the autoethnography with focus group interviews involving 30 participants across three sessions. These sessions were held in DAMEC's training room. We conducted thematic analysis of both the focus group interviews and the autoethnographic narratives.

Findings

The findings of the first phase describe the experiences of forced Iranian migrant men with AOD addiction and mental health issues in Australia.

The overarching themes identified pertain to pre-migration, the migration process itself, and post-migration experiences. These themes encompass the history of drug use and alcohol and other drug (AOD) consumption, the harrowing migration journeys from Iran to Australia, and the associated mental health challenges, including loneliness and mental health disorders. Issues of discrimination, the inability to access necessary assistance, the correlation between alcohol consumption and mental health issues, barriers to establishing a new life, and cultural obstacles to seeking counselling services are also significant.

Additionally, themes emerging from the autoethnography results highlight the challenges faced by female counsellors: the provision of culturally responsive care, the need to connect clients with essential support and resources, the delivery of person-centred care, effective therapeutic strategies, the importance of the counsellor's gender, and beneficial therapeutic processes.

Participants recounted their experiences in their home country, the migration journey, and the prolonged detention in immigration facilities, which resulted in mental distress, depression, anxiety, loneliness, and post-traumatic stress disorder (PTSD). Furthermore, after leaving the detention facility, participants continued to encounter challenges such as difficulties in accessing housing, suitable employment, ongoing loneliness, discrimination and racism, and a lack of access to healthcare services. Collectively, these challenges contributed to the participants' mental health issues and their use of AOD as a coping mechanism.

Using AOD can further exacerbate the mental health issues experienced by Iranian migrant men living in Australia. The participants reported facing difficulties related to language barriers, a lack of culturally competent services, and social factors such as racism and discrimination, all of which contributed to their reluctance to seek and engage with treatment services.

Furthermore, the autoethnography and focus group interviews confirmed that migrants encounter significant challenges while living in a new country. Having migrated from Iran and settled in Australia a few years ago, I experienced various difficulties. Most of these challenges stem from cultural inclinations, as the Iranian culture often perceives women as inferior and unsuitable for roles in female-dominated professions, such as counselling men with mental health and AOD issues. Additionally, the autoethnography and focus group discussions highlighted the difficulties faced by female counsellors in providing services to men dealing with mental health issues related to AOD addiction. Many participants expressed unwillingness to seek services from a female counsellor, indicating the barriers women face when entering and working within this profession.

Over time, the participants became more receptive to my presence, and they expressed satisfaction with receiving mental health and addiction services from a female counsellor who could

communicate in their language. They conveyed that female counsellors with multicultural competence, who delivered care and treatment, significantly enhanced their help-seeking behaviour and involvement in treatment. Their work also contributed to improved awareness and reduced stigma among individuals who had previously been hesitant to seek health care services from professionals with similar cultural and linguistic backgrounds.

Additionally, they noted that beyond receiving mental health and addiction services, my referrals to other organisations, such as housing, employment, and legal services, proved beneficial because they addressed many of their pressing needs. Lastly, they expressed their satisfaction with receiving mental health services in group settings, despite the participants' general preference for individual therapy sessions.

Conclusion

The two substudies that form the foundation of this thesis have enhanced our understanding of the experiences of forced Iranian migrant men regarding mental health and alcohol and other drug (AOD) issues, as well as their engagement with mental health counselling. The findings build upon existing knowledge and have the potential to inform policies and recommendations aimed at addressing mental health challenges within culturally and linguistically diverse communities. The topic is particularly relevant for migrants who face various mental health issues throughout their journey—from their home country, through detention facilities, and into their integration within host societies.

There is a pressing need for an increase in the number of bilingual counsellors, particularly females, who are well-equipped to provide mental health services to migrant men. Their ability to establish trusting therapeutic relationships and effectively connect with and understand clients'

emotions is invaluable. The findings indicate that counsellors should adopt suitable therapeutic approaches tailored to their clients' specific needs and contexts. Furthermore, the research highlights the necessity of reducing stigma, discrimination, and racism, particularly within detention facilities. Such action is crucial for minimising the risk of mental health issues and substance use among migrants while also fostering their engagement with mental health services in Australian society.

The research seeks to fill a gap in existing studies by examining the co-occurrence of mental health problems and substance use disorders among Iranian migrant men in Australia, focusing on their experiences and interactions with therapeutic services.

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Positioning the Researcher

Given the importance of the researcher's involvement in qualitative research, it is crucial to provide a comprehensive account of my history and experience in relation to this subject matter. I am an Iranian female who migrated to Australia in 2014. However, I am now a legal citizen in Australia after acquiring citizenship in 2018. As an alcohol and other drugs (AOD) and mental health counsellor, I began my professional practice in Australia roughly seven years prior to embarking on my doctoral studies at the University of Sydney (USYD). I have worked at the Drug and Alcohol Multicultural Centre (DAMEC) as a bilingual AOD counsellor. While working at DAMEC, I have interacted with several forced-migrated Iranian men who were struggling with their problematic AOD consumption and mental health issues. I have professional experience in providing services to diverse client populations, including individuals, couples, and families. I have gained professional experience in several roles across both public and private mental health sectors, including jobs in counselling services and a mental health clinic within a rehabilitation hospital. These opportunities have afforded me the chance to engage with individuals situated at various points along the continuum of health. Following my departure from Iran, I engaged in a clinical role within a multicultural AOD and mental health program. During this period, my professional responsibilities encompassed developing and implementing intervention plans for individuals struggling with addiction and their respective spouses and families. It is important to note that a significant portion of my clientele consisted of individuals of Iranian descent during the aforementioned period. However, it is important to acknowledge that a subset of couples within this group had been compelled to relocate to Iran due to various circumstances, including but not limited to political unrest and conflicts in surrounding nations such as Afghanistan and Iraq. As an

individual of foreign origin residing in Australia, I have encountered various experiences that align with those of the substantial migrant population within this multicultural country.

My understanding of the realities faced by individuals seeking assistance for alcohol and other drug issues greatly deepened when I began to build my social network within the Iranian Narcotics Anonymous (NA) communities in Australia. As an Iranian migrant living in Australia, I faced numerous challenges related to acculturation, a diminished sense of belonging, discrimination, and insufficient support. These personal experiences have significantly enhanced my capacity for empathy when engaging with my research subjects and attentively listening to their stories. However, it was essential to carefully assess the differences between my experiences and those of the participants. As a married individual pursuing further education and working as a counsellor, I arrived in Australia through legal means. I aim to gain insights into the lives of Iranian forced migrants who have come to Australia. To address the potential negative consequences stemming from status disparities, establishing rapport became a vital step in fostering trust. Creating a sense of comfort and security proved to be challenging for me as a female counsellor of Iranian descent. This challenge stemmed from the apprehension, societal stigma, cultural factors, and the prevailing influence of masculinity exhibited by male clients during our interactions. While most of the participants were past clients I had served, some were unfamiliar to me. The new participants were hesitant to share their past experiences. Consequently, I had to reassure them of my good intentions; however, when I spoke Farsi, they began to develop a sense of trust towards me.

Throughout the participant recruitment process, I felt supported by the preexisting trust established between me and the clients, particularly those I had served during my tenure as their counsellor. The participants conveyed a heightened sense of safety and comfort while discussing their experiences within the focus group, especially when conversing in Persian, in my capacity as the

researcher. Furthermore, there was no requirement for them to explain their culture, which reduced the likelihood of cultural misinterpretation. The author's prior professional background and expertise in the implications of forced migration shaped my assumptions about the disadvantages of forced migration, particularly from a trauma-informed perspective.

In addition to conducting interviews and enhancing my comprehension of the complete spectrum of potential outcomes, this research has influenced my perspective in two distinct manners. Initially, this endeavour elicited a sense of empathy inside me regarding the enduring psychosocial and political hardships that exert influence over the lives of individuals who have been compelled to migrate against their will. Given my extensive knowledge of Iranian culture and its impact on women's perceptions of freedom and equality in the Australian context, it was imperative for me to critically examine my biases while examining the gender-related data. Prior to undertaking this research, I held a positive outlook towards migrant women, as I perceived them to be liberated from the patriarchal societal norms and legal frameworks. Additionally, I harboured optimism regarding the potential growth and development of men in terms of their comprehension and practice of fostering equality within their relationships with women. The primary aim of this study was to facilitate the expression of participants' voices and present a full portrayal of their lived experiences. Furthermore, I would like to provide my perspective as an Iranian female who collaborates with Iranian men who are engaged in addressing AOD as well as mental health concerns. This experience was of utmost importance and served as a source of motivation for me to navigate through the challenges encountered during the research process.

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List of Abbreviations

ABS: Australian Bureau of Statistics

AIHW: Australian Institute of Health and Welfare

AOD: Alcohol and Other Drugs

CaLD: Culturally and Linguistically Diverse

DAMEC: Drug and Alcohol Multicultural Education Centre

DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th edition

EMCDDA: Monitoring Centre for Drugs and Drug Addiction

FGD: Focus Group Discussion

GP: General Practitioner

ICD: International Classification of Diseases

IHRA: International Harm Reduction Association

IPA: Interpretative Phenomenological Analysis

NA: Narcotics Anonymous

NHMRC: National Health and Medical Research Council

NSW: New South Wales

PTSD: Post-Traumatic Stress Disorder

SAMHSA: Substance Abuse and Mental Health Services Administration

SUD: Substance Use Disorder

SUP: Substance Use Problem

TA: Thematic Analysis

UNODC: United Nations Office on Drugs and Crime

USYD: University of Sydney

1. Introduction

1.1. Background Information

Substance use and mental health issues are the major causes of disability globally, accounting for 23% of lost life years. Substance use disorders affect 31 million people, and harmful consumption of alcohol alone results in 3.3 million deaths annually (Idowu et al., 2018). Co-occurring mental and substance use disorders can lead to poor quality of life. Individuals with co-occurring substance use and mental health issues are typically labelled "complex", "hard to reach", or "difficult to engage" in treatment due to limited specialised resources (Harvey et al., 2020; Substance Abuse and Mental Health Services Administration (SAMHSA), 2023).

Compared to the general population, migrants are more likely to experience a range of mental health issues, including distress, feelings of hopelessness, sadness, anger, fatigue, difficulty sleeping, pain, and irritability (World Health Organisation, 2021). A systematic review conducted by Blackmore et al. (2020) found that asylum seekers and refugees exhibit particularly high levels of mental health problems, notably post-traumatic stress disorder and depression, which are more prevalent than in the general population.

Migrants are particularly vulnerable to substance abuse, often misusing alcohol and other drugs. This vulnerability stems from their disadvantaged circumstances in host countries. Previous literature suggests that migrants experience higher rates of common mental health issues, particularly depressive symptoms, compared to the native-born population (Hasan et al., 2021). Additionally, studies indicate that migrants may lack awareness of the mental health treatments available to them, or they may be completely unaware of such options due to limited integration

into mainstream culture (Dinos et al., 2017). The cultural backgrounds of immigrants significantly shape their understanding of mental health issues, influencing their perceptions of their conditions and their expectations from treatment. Furthermore, it has been suggested that culture plays a role in how immigrants manage their mental health challenges, substance use issues, and help-seeking behaviours (Hagmayer & Engelmann, 2014; Krimayer et al., 2011). Mental health issues among migrants are often linked to a variety of pre- and post-migration factors, including difficulties with acculturation, low socioeconomic status, unemployment, social exclusion, discrimination, feelings of powerlessness, and a sense of unworthiness (Chen et al., 2017).

Australia has transformed into an ethnically diverse and multicultural nation in recent decades, largely due to an unprecedented rise in immigration (Klein, 2016). It is estimated that approximately seven million individuals have migrated to Australia since the early 1940s. This rate equates to nearly 45 per cent of the population being either born abroad, having one parent born overseas, or both parents originating from another country. Currently, the Australian Bureau of Statistics (ABS) estimates that 28.2% of Australia's resident population was born abroad, a figure considered unusually high compared to most other OECD countries (Phillips & Simon-Davies, 2016). In the year ending March 2023, Australia recorded a net intake of 454,000 migrants, with 152,000 arriving in that quarter alone. This surge was driven by sustained strength in arrivals and a decline in departures. Net overseas migration (NOM) contributed 0.6 percentage points to the quarterly population increase (Centre for Population, 2023).

While some Iranian migrants have come to Australia as skilled professionals meeting the demand for their expertise, the majority of Iranian migrants are compelled to migrate due to political and economic instability in their home country. The migration experience is often an active process that involves various changes and challenges, with notable differences in how

migrants respond to migration and its impacts (Wong & Miles, 2014). Similarly, migrants and humanitarian refugees face several stressors during the immigration process (Mwanri & Mude, 2021). Research on African migrants, the majority of whom arrived in Australia as refugees, has identified significant stressors related to housing, employment, education, and integration following their arrival (Wood et al., 2019). Moreover, there are distinct and varied movement patterns that occur both within and across immigrant and refugee groups. Pre-migration contexts, which encompass cultural backgrounds, places of origin, and the circumstances surrounding immigration decisions, can have various adverse effects on individuals and communities, including negative impacts on mental health (Li et al., 2016).

There are many factors behind the mental illness of forced migrant Iranian men. One of them is separation from family and friends, which causes dislocation, stress, and severe depression. Along with it, the issues related to their visa status, employment, and lack of basic hygiene and nutritional requirements push them to mental illness. It creates difficulties for them to manage their emotions because they are unable to deal with depression, anxiety, and insomnia (Shishehgar et al., 2015).

Despite experiencing high levels of mental health challenges, migrants have been reported to have lower rates of using mental health services, such as seeking counselling services from designated service providers (Abebe et al., 2017). In addition, recent research has pointed out that migrants report unmet needs even while in treatment centres and have lower therapeutic relationships and tend to experience social exclusion and discrimination compared to other populations (Knapstad et al., 2018).

Forced migrants struggle to comprehend their deteriorating wellbeing and are hesitant to discuss their mental health issues with others due to feelings of embarrassment. Along with it, the

language barrier is a major obstacle to communicating with others and getting assistance to improve their mental health (Shishehgar et al., 2015). However, they are willing to trust bilingual counsellors for assistance. This is mainly because working with the interpreter is difficult (Australian Government, 2019). More importantly, immigrants and refugees are under-served by AOD and mental health services in Australia and are even at increased risk of being overlooked in the context of mental health policy and planning (Sullivan et al., 2020). This inequity in the representation of Iranian migrants among individuals who are at increased risk of using illicit substances, experiencing mental health problems, and under-utilising AOD and mental health services necessitates further research to understand this community as well as the effective therapies and other approaches for effectively dealing with forced migrant men who consume AOD alongside their mental health issues.

Further, there has been no recent qualitative study exploring AOD consumption and mental health services, including counselling, from the perspective of Iranian male migrants in Australia. This gap highlights the urgent need for research in this area to better recognise the complicated nature of the phenomenon. This situation serves as one justification for conducting a qualitative study aimed at describing the phenomenon and interpreting its significance. Such studies concentrate on the interpretations, experiences, and perspectives of participants to aid in constructing concepts that help people better comprehend natural phenomena (Al-Busaidi, 2008; Busseto et al., 2020).

1.2. Aims and Objectives

The specific aims and objectives pertinent to this thesis are as follows:

1. To explore the relationship between alcohol and other drug (AOD) consumption and mental health issues among forced migrant Iranian men in Australia.

2. To critically reflect on the experiences of bilingual counsellors in addressing alcohol and other drug (AOD) consumption and mental health issues within forced migrant Iranian men in Australia through an autoethnographic study.

1.3. Research Questions

This thesis will use data from both phases of the study to answer the following two questions:

1. What are the experiences of alcohol and other drug (AOD) consumption and mental health issues among forced migrant Iranian men in Australia?

2. What insights do bilingual counsellors gain from providing counselling services to forced migrant Iranian men in Australia who are facing alcohol and other drug (AOD) consumption and other mental health issues?

Furthermore, this thesis is grounded in the fundamental premise that AOD use, mental health issues, and immigration represent significant disruptive events in life. An approach informed by phenomenology was explored to facilitate the examination of the meaning behind the lived experiences associated with such discontinuities. These disruptive events hold particular significance for the study's subjects, who have migrated due to stressful circumstances in their home countries, including trauma from warfare or the pursuit of family reunification. In response to these upheavals, they have turned to AOD consumption as a means of coping with and making sense of the changes.

The following methods are used to achieve the aims of the research:

1. Conducting focus groups with forced migrant Iranian men in Australia experiencing AOD and other mental health issues.

2. Utilising autoethnography analysis by the researcher to reflect on experiences as a bilingual counsellor providing therapeutic services to forced migrant Iranian men in Australia and their interactions with an Iranian female counsellor.

1.4. Significance of the Study

This study explored the experiences and perspectives of Iranian migrant men who have moved to Australia, focusing on their AOD consumption and mental health problems related to the migration process, resettlement, and their life there. The study will help understand how the specific social-cultural backgrounds of Iranian migrant men contribute to their mental health experiences and AOD misuse. It is imperative to understand whether Iranian migrant men are attentive to or seek treatment for mental health issues related to their integration process in the Australian culture. The findings of this study will help raise awareness regarding mental health issues and tendencies to AOD consumption among Iranian migrant men in the Australian sociocultural context. Mental health professionals and counsellors can use this knowledge to implement culturally sensitive and appropriate counselling strategies that effectively address mental health issues and AOD consumption among Iranian migrants. Further, the findings of this study can be a source of information for migration practitioners and policymakers in Australia since they can use it to lessen the severity of migrants' experiences while there. The research findings will help Iranian men improve their standard of living as they try to integrate into the new social and cultural context.

Furthermore, the significance of this research study lies in its focus on forced migrant Iranian men and their experiences with AOD use and mental health, a population that has been relatively understudied compared to migrant Iranian women or young people.

The use of qualitative and autoethnographic methodologies allowed both participants and the counsellor to collaboratively explore and share their challenges and issues, providing a rich understanding of their journeys. The study's unique approach, incorporating social constructivism and feminist frameworks, sheds light on the complexities of the participants' lives before and after counselling, with the researcher's dual roles as a counsellor and a woman adding a personal dimension to the study.

1.5. Thesis Outline

Chapter two of the research project provides the theoretical background for this thesis. It covers key concepts such as migration, cultural competence, mental health, and AOD, along with their relationships to immigrants' backgrounds. The chapter also sheds light on how these concepts relate to the objective of this study.

Chapter three offers an overview of the relevant literature pertaining to this thesis. The literature reviewed focuses on the migration of Iranian men to Australia, addressing issues such as the causes and experiences associated with Iranian migration. Additionally, Chapter 3 will examine the programs, legislation, and policies that are relevant to migratory processes. It will also outline the migration journey from Iran to Australia. This chapter further investigates migrants' access to mental health and social services, as well as the ways in which both local and international legislation is being enacted in response to these issues. In particular, the chapter discusses topics including mental health, the challenges faced by migrants, acculturation, enculturation, and drug

abuse among migrants, along with various treatment approaches. Finally, the chapter addresses the effects of migration on the mental health of Iranian migrant men.

Chapter four aims to elucidate relevant theories that are integral to this thesis. Throughout the literature review, it became evident which concepts are most commonly employed to elucidate the impact of migration on mental health. The first of these ideas is migration theory, which analysts have backed by outlining the different reasons for migration and the routes people take. Furthermore, the theory of acculturation, particularly Berry's (1997) model, is crucial as it will be referenced later in the thesis to aid in the interpretation of the findings. This chapter also encompasses a comprehensive examination of several theories related to substance abuse, addiction, and recovery, providing additional context for understanding the reasons behind substance use, abuse, and recovery processes. A review of help-seeking theories is included to clarify why seeking assistance can often be challenging, particularly regarding mental health and accessing care in a foreign country. Additionally, the chapter briefly discusses theories such as person-centred theory and culturally competent care, which I regularly apply to delivering services to CaLD clients. Finally, the chapter explores the application of feminist theoretical perspectives within Persian culture, specifically concerning the support of Iranian men dealing with AOD disorders and mental health issues. This analysis incorporates elements such as the influence of social divisions, feminist theory, human behaviour within the feminist framework, diverse feminist perspectives, a commitment to creativity, and the evolution of the patriarchal system.

Chapter 5 provides a detailed examination of the research approach, techniques, and procedures utilised for this thesis. It explains the study paradigm pertinent to the objective and nature of this study and answering the research questions identified in chapter one. This chapter covers a variety of topics. After a brief introduction to the chapter, the following sections provide

a detailed description of the research methodology employed in this thesis. It then discusses the research paradigm from ontological, epistemological, and axiological angles. The discussion is followed by the study design adopted in this thesis. Specifically, this section explains why an exploratory study design is appropriate for this research. Next, I discuss the research approach that guides the data collection process, including the justification and rationale for using qualitative research that relies on in-person interviews. This section covers the participant sampling structure, the justification for the sampling methods, and the final data-gathering procedures. The chapter also explores data analysis methodologies by outlining the thematic data analysis approach. The approach includes the process of identifying themes within focus group discussions, which involves transcription, a thorough reading of the transcribed data, coding, identifying subthemes, and ultimately generating themes based on the identified subthemes.

Lastly, ethical considerations such as approval from the ethical committee, seeking consent from the participants, and how to ensure subjectivity in my relationship with the participants since I had a pre-existing relationship with some of the participants. Further, I discussed the rigour issues of the study findings, including how to ensure trustworthiness, reliability and validity of the study are discussed. The chapter concludes with a brief summary.

Chapter 6 delves into the process. This research integrates narrative autoethnography as a central methodological approach, positioning my lived experience as a counsellor working with forced migrant Iranian men facing co-occurring mental health and alcohol and other drug (AOD) challenges. By drawing on my professional practice, personal reflections, and interactions in clinical and community settings, this approach allows for a deeply contextualised and emotionally resonant exploration of culturally nuanced care. The autoethnographic methodology chapter outlines how my narrative was used as both data and a lens, allowing readers to understand the

ethical complexities, relational dynamics, and structural challenges encountered in this work. This reflective inquiry not only bridges the personal and professional but also critiques and reimagines service provision for marginalised populations from within.

Chapter seven presents the result and findings derived from individual focus group interviews conducted with the study participants. This chapter outlines the emerging themes from the narratives shared by the participants, focusing on their personal journeys to Australia, their lived experiences in the host country, their use and accessibility of AOD, and their engagement with mental health services. Also, chapter seven presents the findings from both autoethnographic and focus group interviews, delving into my experience as a female counsellor and an Iranian migrant. This chapter encompasses autoethnographic reflections on my journey since migrating from Iran to Australia, alongside my interactions and work with forced Iranian migrant men facing mental health challenges and substance use disorders. Additionally, it describes participants' perceptions of female counsellors and their experiences receiving mental health services from them.

Chapter eight presents the results, while chapter nine is dedicated to the discussion, and the final chapter offers a conclusion. In chapter eight, the results from the Interpretative Phenomenological Analysis (IPA) and autoethnographic methods are combined with the results from the earlier chapter. These findings are compared to previous studies concerning migrants' experiences with mental health issues, the harmful use of AOD, and the obstacles faced when accessing mental health and counselling services in a foreign country. Based on the findings of this thesis, chapter nine discusses research implications and provides recommendations aimed at improving mental health and counselling services for migrants in Australia, as well as suggesting avenues for further research. Finally, a detailed conclusion of the thesis is presented in chapter ten.

2. Conceptual Background

2.1. Introduction

This chapter presents a thorough literature review, centred on research pertaining to migrants in a new country and the challenges they encounter throughout their journey and subsequent settlement. The discussion covers the impact of migration on mental health, the potential for AOD use disorders among migrants, and the obstacles they face in accessing mental health services. I organised the chapter into five sections and concluded with a summary. Section 1 offers an overview of migration studies, section 2 investigates the intersection of migration and culture, section 3 analyses the relationship between migration and mental health, section 4 discusses migration-related substance use disorders, and section 5 highlights the reluctance of immigrants to seek mental health services.

2.2. Migration - An Overview

This section furnishes background information and historical context for migration to establish the research framework. Migration has persisted throughout history, both in Australia and globally. Migration is a significant and complicated phenomenon that has presented both opportunities and challenges, and it is currently at its peak intensity (Boghean, 2016). According to the 2020 World Migration Report, the number of global immigrants was around 281 million in 2020, up from 248 million in 2015 (McAuliffe & Khadria, 2019). Migration can be driven by various factors, including politics, culture, economics, and the environment. Landmark events can shape the migration of individuals or groups based on political, social, and geographical contexts (Kumar & Diaz, 2019). Individuals may migrate for educational or economic reasons and

subsequently be joined by their families, whereas people who migrate in groups may do so for political purposes, either alone or with their families. Individuals migrate to enhance their standard of living or lifestyle, especially where there exists an income differential between their country of origin and the country they migrate to (Uprety, 2019). Moreover, individuals may prefer to move to other countries if they are unable to find suitable opportunities in their origin (Simpson, 2022).

Further, Chance (2023) maintains that the desire to migrate could be influenced by nature or be a result of the external factors. An unfavourable political setting, a problematic social structure, and a poor legal system can force people to migrate to other developed places (Oucho & Williams, 2018). The host country's economic and political situations may also have an impact on immigrants' ability to contribute to economic growth. For example, a robust economy with low unemployment rates and high labour demand may create more opportunities for immigrants to find work and contribute to economic growth (Chance, 2023). Other authors contend that economic variables such as labour demand, wages, and employment opportunities can attract or repel immigrants, but political conditions, such as immigration policies and social views towards immigrants, can also influence their economic prospects (Chance, 2023).

Migration is typically divided into three stages: premigration, migration, and postmigration. The first stage, pre-migration, comprises deciding and preparing to relocate. The second stage, migration, is the physical relocation of an individual or group from one site to another. The third stage is postmigration, which involves assimilating the immigrant into the new social and cultural framework (Bhugra et al., 2021). Migration is much more complex than a straightforward journey from one location to another and may involve multifaceted and diverse patterns depending on societal dynamics and individual requirements (Abubakar et al., 2018).

Migration is now recognised as a distinct factor influencing the health of migrants (Marmot et al., 2012). Migration and health are dynamic, and various pre- and post-migration factors can combine to impact immigrants' health. Various variables can contribute to mental health issues during relocation. Pre-migration factors include forced migration, persecution, and loss of family members.

In the course of the post-migration phase, the individual becomes an "immigrant" in the host country. Post-migration factors may include culture shock, unmet expectations, being accepted and assimilated into the new culture, and access to support networks. Studies have repeatedly documented concerns for the welfare of distant family members and the desire to reunite with said family members as prominent priorities for refugees in the post-migration period (Miller et al., 2018). Additional financial pressures, such as increased cost of living, make it difficult for migrants to visit their family members back at home or stay with them in the host country (World Economic Forum, 2017).

Immigrants undergo both physical and mental changes upon arriving in their new country (Cormoș, 2022). Psychosocial changes—such as the loss of cultural identity and professional status, the severing of kin and social networks, and the difficulty in forming new relationships within different societal norms—can be particularly challenging to navigate. Many of these changes are linked to increased levels of stress, which can adversely affect the mental health of migrants (Bhopal, 2014). Consequently, both the migration process and the period following migration can be characterised as stressful, with the adjustment to a new country and environment presenting unique health risks related to mental well-being (Kumar & Diaz, 2019).

In addition, compared to the general population, immigrants experience greater barriers to healthcare access than the normal population, resulting in unmet health requirements (Hasanali,

2015). These challenges can be attributed to various factors, including cultural and financial barriers related to the host country's healthcare, as well as discrimination, racism, lower education levels, lack of employment, and often self-neglect. The transition process for immigrants may create a liminality situation amongst themselves, as they shift from an increasingly predictable past to a highly unpredictable future, and thus they are likely to suffer from ambiguity (Hasanali, 2015).

The term "liminality" was introduced by Turner (1982, cited in Küpers, 2011) to describe a state of being in an ambiguous condition that lies within the confines of both established and emerging social structures. According to Turner (1982, p. 27; Küpers, 2011), liminal individuals find themselves in a vulnerable position, existing in a space between the roles assigned by custom, law, convention, and ceremony. For numerous immigrants, social exclusion—linked to various disadvantages—hinders their ability to integrate smoothly into the host society and contributes to mental health challenges, resulting in the inevitable experience of marginalisation. Often, these immigrants turn to substance use, particularly when their state of liminality becomes unbearable. Consequently, this thesis posits that migration can place considerable stress on migrants' lives.

2.3. Migration and Culture

This research, which focuses on Iranian migrant men, points out the value of discussing culture and its relationship with migration. Thus, I aim to further explore the intersection of migration and culture in this section. Culture is a fundamental element of human existence, and understanding an individual's background is essential for comprehending their behaviour. Every individual carries their culture with them to their current places of residence; however, migration

studies often fail to adequately represent this cultural aspect (Contini & Carrera, 2022; Hruschka, 2009).

Culture can be defined as a set of beliefs, values, expectations, rites, and rituals that dictate how people interact, feel, think, and act when they encounter others and their environment (Werneke & Bhugra, 2018). Furthermore, Kagawa and his colleagues articulate that culture is not static but rather a continuously evolving construct that enables humans to adapt to changing physical, social, and political contexts (Kagawa-Singer et al., 2010; Singer et al., 2016). They also emphasise the importance of acknowledging the influence of culture on individuals or groups, as culture shapes how they interpret their surroundings through shared ideas, behaviours, and spiritual and emotional frameworks (Kagawa-Singer et al., 2010). In this context, cultural norms and tools are established from the perspectives of being members of a particular society, thereby allowing group members to derive meaning in life through a sense of belonging, safety, integrity, well-being, and connection within their social networks (van den Berg & Beun, 2021; Kagawa-Singer et al., 2010).

This also influences the distribution of power among various groups within the cultural population, including genders, immigrants, and service users. Additionally, it affects the attitudes and actions individuals adopt to understand concepts such as health, illness, and death; stigma; help-seeking; and the role of being a valuable and constructive member of society (Kagawa-Singer et al., 2010; Kjøllesdal et al., 2023). This implies that understanding culture is essential for grasping how a person behaves in specific situations and that mobilising cultural processes could enhance health outcomes by moderating interactions among various environmental factors that are both multidimensional and multilevel (Singer et al., 2016).

When individuals migrate from one location to another, their cultural identity may undergo various changes. The degree of this identity transformation is influenced by factors such as the migrant themselves, family members left behind in the country of origin, and the societal elements present in the host country. The interactions among these factors impact all three categories of individuals (Cormoș, 2022; Epstein & Gang, 2010). Regardless of their reasons for migrating, migrants retain their beliefs and expressions of distress. Consequently, these beliefs significantly influence their idioms of distress, which in turn affect how they manifest their symptoms and their willingness to seek help when facing mental health challenges.

The migration process itself can be stressful, varying based on the type and reason for migration, and can profoundly affect the mental health of both the migrant and their family (Bhugra & Becker, 2005; Marguerit, D., & Scrivens, 2017). Immigrants often find it difficult to navigate the cultural values, socio-political context, and instances of racism within the host country. Furthermore, migrants have diverse mental health needs shaped by their experiences in their home country, their journey, the entrance and integration policies of the host nation, and their living and working conditions (WHO, 2022a).

Many challenges arise when a migrant's background differs significantly from that of the host country. Individuals from rural areas who leave their countries of origin often struggle to adapt to the lifestyle and customs of their new environment. This includes difficulties adjusting to different eating and dressing habits, navigating a fast-paced and sometimes perilous society, and acclimating to a rhythm of life that starkly contrasts with that of their homeland (Cormoș, 2022). In this context, migrants sever ties with their previous environment, from which they retain certain habits, thought processes, emotional responses, and behaviours, and instead adopt specific actions necessary for integration into the new community (Cormoș, 2022).

The degree of acceptance by the "majority" culture, as well as the similarities or differences between the culture of origin and that of the host country, significantly influence the prevalence of mental health issues among immigrants (Mera-Lemp et al., 2020; Bhugra & Becker, 2005). Furthermore, the impact of culture on mental health problems in migrants is contingent upon how well they accept and adapt to the culture of their new society. This concept relates closely to what is known as acculturation. Acculturation refers to the process of cultural exchange and adjustment that occurs when two distinct cultures interact (Sam & Berry, 2010; Schmitz & Schmitz, 2022). Berry (2019) defines acculturation as involving changes in cultural and behavioural values that arise from interactions between individuals or groups from different cultures. Such changes tend to occur more frequently as individuals from diverse cultural backgrounds engage and cooperate with one another (Berry, 2019). Over time, these interactions can lead to psychological, emotional, and cultural transformations (Sam & Berry, 2010; Mera-Lemp et al., 2020).

To address the distress associated with acculturation, various patterns are employed that reflect beliefs, attitudes, and behaviours related to both the culture of origin and the host culture. The bi-dimensional model proposed by Berry (1997) and cited in Klein et al. (2020) identifies four acculturation strategies: assimilation, separation, marginalisation, and integration. Assimilation is characterised by a strong commitment to the culture of the receiving society, with minimal retention of the original culture. In contrast, separation involves a significant preservation of the traditional culture and limited interaction with the host community (Klein et al., 2020). Marginalisation implies a lack of participation in both cultures. Finally, integration involves deep engagement and participation in both the culture of origin and the host culture (Berry, 1997; Klein et al., 2020).

Immigrants often face challenges in understanding the cultural values, socio-political context, and experiences of racism within the host country. They possess a diverse range of mental health needs influenced by their experiences in their home countries, their migration journeys, the host nation's integration policies, and their living and working conditions (WHO, 2022a).

Various studies have demonstrated that integrated acculturative patterns serve as protective factors for psychological and emotional adaptability, whereas marginalisation is associated with adverse health outcomes (Berry & Hou, 2016; Nakash et al., 2012). Specifically, experiences of alienation, rejection, and mental distress are often triggered by a lack of acceptance from the majority culture, coupled with separation from the immigrant's own cultural background (Bhugra & Becker, 2005; Smeekes & Jetten, 2019). Cultural differences significantly influence how these feelings of illness and distress are recognised and addressed, with culture playing a crucial role in shaping the presentation of these experiences (Bhugra et al., 2011; Smeekes & Jetten, 2019). This influence is particularly pronounced in multicultural societies, where the dominant culture is expressed through social institutions, such as the healthcare system, which defines the issues, and social or cultural distinctions deemed significant enough to warrant attention.

2.4. Migration and Mental health

To provide context for the research, this section presents background information on the relationship between migration and mental health. Mental health problems (MHPs) are defined as any emotional, behavioural, or developmental issue experienced by individuals (WHO, 2022b). In this study, MHPs are used to assist individuals with understanding their own mental health conditions. This approach acknowledges that people's perceptions of mental health disorders can change throughout their lives. Mental health issues may be characterised by an individual's internal

and external experiences during periods of personal distress or temporary loss of autonomy. Furthermore, the term ‘mental health problem’ is regarded as a complex and multifaceted phenomenon (Alamsyah, 2023), arising from the realities of an individual’s lived experiences, which are inherently multidimensional (Malla et al., 2015).

Migration is closely associated with mental health problems. As individuals relocate, they bring with them an awareness of distress (Virupaksha et al., 2014). Migrants are particularly susceptible to mental health issues due to various stressors, including separation from family, cultural and linguistic differences, hostility from the host nation, and traumatic experiences in their country of origin. The author posits that individuals transitioning from collectivistic to individualistic societies may find it challenging to assimilate into the new culture. Tourneur et al. (2015) note that migrants often have to leave behind friends, family, homes, and their cultural identities. Matud et al. (2020) assert that stress is an inevitable part of life, but the migration process uniquely exposes immigrants to a range of stressors, such as the loss of loved ones and their homeland, alongside social, emotional, and financial difficulties that can adversely affect their well-being (Bustamante et al., 2018). This predicament may stem from insufficient social support and unrealistic expectations, potentially leading to low self-esteem and an elevated risk of mental health issues (Bhugra & Becker, 2005; Hou et al., 2020). It is further argued that migration, coupled with feelings of alienation and dislocation, can induce stress for individuals and families, although mental health experiences can differ greatly among various groups and individuals (WHO, 2021). Moreover, recent systematic reviews indicate that a significant majority of refugees and forced migrants residing in Western nations suffer from post-traumatic stress issues (Fazel et al., 2005; Hameed et al., 2018).

Various studies, including those by Okruszek et al. (2015) and Lim et al. (2020), have demonstrated that ongoing difficulties such as isolation, distress, long-term unemployment, and loneliness can lead to anxiety and depression more significantly than recent life stressors. However, the risk of developing psychological problems may differ from individual to individual, influenced by personality traits such as a propensity to worry excessively, sensitivity to criticism, or self-criticism (Pérez-Chacón et al., 2023). Immigrants, who may already be vulnerable due to past adverse experiences or personal factors, might encounter psychological issues triggered by a combination of stressors. The nature of these stressors can vary widely among individuals; some may struggle due to living alone, while others may face challenges from living in crowded conditions. This concept is further supported by a hypothesis proposed by Cochrane and Bal (1987), as cited in Selten et al. (2020), which posits that the elevated levels of mental health problems among immigrants are linked to the high prevalence of mental health issues in their countries of origin.

2.5. Migration and AOD problem

I aim to explore the connection between AOD misuse and migration, following the discussion of the relationship between migration and mental health in this section. We interchange the term AOD with substance use disorder (SUD) or substance use problem (SUP). Terminology surrounding AOD use can often be confusing and misleading. Variations in terminology exist across countries and specialities, including within Australia. Such discrepancies can lead to misunderstandings when discussing AOD and its users. It is essential to employ effective language when addressing AOD issues and mental health, as these topics can evoke strong emotions and be misinterpreted or sensationalised, which can result in stigma and prejudice. (Mental Health Commission, 2022).

In this thesis, I will use the term AOD to refer to SUP, encompassing a wide range of subjective experiences related to the consumption of alcohol, substances, or even psychotropic drugs. This approach is particularly important for this study, as the significance of AOD use varies from person to person. Investigating these individual experiences will enhance our understanding of the lived experiences associated with the phenomena under study. Substance use disorders include harmful patterns of drug and alcohol use and dependence (National Collaborating Centre for Mental Health et al., 2011).

Immigrants' health behaviours, especially substance use, can be influenced by their migration experiences. Furthermore, SUP may vary throughout the migration process, depending on exposure to various environmental and cultural factors (Zhang et al., 2015). Moreover, assimilation into a culture of dominance can lead to increased consumption of AOD among immigrants, especially if the culture does not value diversity. Assimilation into a new culture can cause family problems due to varying degrees of acculturation between parents and children. These circumstances can cause problems between generations, including personal discomfort, delinquent behaviour, and substance use (Dalla et al., 2009; Kim et al., 2020).

Migrants may use substances to cope with pressures such as trauma, loneliness, negative emotions, and insecurity. According to Marquez-Arrico et al. (2019), individuals with limited coping methods are more likely to use substances when faced with new stressors during migration. Many people use substances for self-medication due to daily psychological and physical discomfort, which can progress to substance use disorders (Marquez-Arrico et al., 2019).

Research suggests that individuals with co-occurring disorders may struggle to engage in treatment, leading to significant dropout rates (Dixon et al., 2016). Low participation among these individuals can lead to poor therapeutic results, relapses, and rehospitalizations. Engagement in

treatment settings is influenced by various factors, including therapeutic alliance, utility, accessibility, trust, and coercion (Dixon et al., 2016). Engaging users from diverse ethnic and migration backgrounds can be challenging due to systemic, social, and cultural barriers (Bø, 2015; Dixon, 2013).

2.6. Immigrants' Reluctance to Seek Mental Health Services

As the factors that influence perception and engagement with treatment services, specifically attitudes, help-seeking behaviour, and the effectiveness of services and support available to forced Iranian migrant me, could be related to the aim and objective of this study, I have chosen to review existing literature and studies on healthcare services for migrant populations.

Immigrants from diverse ethnic backgrounds and migration histories face similar challenges in accessing and receiving mental health services in the host state (Rowe, 2014; Mond et al., 2020). Barriers to mental health care for migrants include a lack of awareness, stigma, economic hardship, and inadequate training for healthcare workers (Wohler & Dantas, 2017). Furthermore, the five main types of barriers to mental healthcare are language problems, different views on mental illness, worries about privacy, the effects of stigma and reluctance to get help outside of personal connections, and lack of social support. These obstacles bear some resemblance to the well-publicized general healthcare field. Nonetheless, the unique characteristics and societal implications of mental illnesses may result in more challenges when trying to get care (Giacco et al., 2014).

Effective communication between professionals and client patients is crucial in mental healthcare, as diagnostic processes rely on verbal communication rather than physical

examinations. Recent studies found that mental health practitioners in different countries have significant challenges when detecting symptoms, diagnosing client patients, and building relationships with immigrants (Laverack, 2018; Sandhu et al., 2013). Individuals who use AOD may face stigma at personal, societal, and institutional levels, according to a recent argument. Such experiences can have negative social consequences, leading to a reluctance to seek assistance (Mental Health Commission, 2022).

Ethnic and language barriers hinder individuals from forced migrant backgrounds in seeking assistance from various services (Rowe, 2014; Mond et al., 2020). Among forced migrants, trauma-related disorders, including PTSD, are prevalent forms of mental illness (Mond et al., 2020). Identifying and understanding mental illness is crucial for migrants; however, research indicates that many do not perceive themselves as experiencing any form of mental illness, and a minimal percentage actively seek help for their difficulties (Mond et al., 2020).

In summary, the main factors contributing to the reluctance of forced migrants to seek assistance include their awareness of mental illness, a lack of understanding, feelings of shame and fear about disclosing personal issues, language and ethnic barriers, and a diminished recognition of the need for treatment (Mond et al., 2020).

2.7. Summary

In this chapter, which is directly aligned with the research aims and questions, I examine the significant impact of migration on the mental well-being of migrant individuals. I emphasise how the process of resettlement in a new country, coupled with the numerous challenges they faced during their journey, can lead to a range of mental health issues. Furthermore, I explore existing literature that illuminates the complex relationship between migration and mental health,

demonstrating how these factors may drive individuals to use AOD as a coping mechanism to manage the difficulties encountered while transitioning from their home country to a new environment.

Lastly, I provide an in-depth overview of the barriers that prevent migrant individuals from seeking help and suggest potential strategies that could be instrumental in supporting this population in effectively addressing mental health concerns and AOD misuse.

3. Review of Relevant Literature

3.1. Introduction

This chapter aims to contextualise the specific objectives of the thesis by presenting relevant literature. The literature is organised into three sections. The first section discusses migration trends in Australia. The second section examines literature concerning mental health issues related to migration, drawing from both international and Australian contexts. In the final section, I summarise the existing knowledge regarding migrants' interactions with counselling services and providers, as well as the ways in which they seek assistance from available health services.

3.2. Migration to Australia

Australia's demographic history over the past century has been shaped by multiple waves of migration and periods of baby booms. The country's population has grown approximately fivefold in the last century, reaching around 25 million, with about seven million of these inhabitants being migrants (Department of Home Affairs, 2018). Since 2006, changes in Australia's immigration policy have resulted in an increase in the number of skilled migrants, contributing to a notable rise in the percentage of the population born overseas. Throughout the latter half of the 20th century, migration continued in response to humanitarian crises in Eastern Europe and Asia, alongside population growth and economic development (ABS, 2022). Over the past 40 years, Australia has become increasingly multicultural, with a growing number of individuals born abroad, particularly from Asian nations, emerging as significant sources of immigration (ABS, 2021). Additionally, the proportion of households where the reference person

was born in Australia decreased from 72% in 1981 to 65% in 2021 (Qu et al., 2023). While immigrants in Australia originate from various countries and regions, including Africa and the Middle East, Iranian migrants constitute a notable segment of the Australian population. In the past decade, there has been a substantial influx of Iranian individuals to Australia. The Australian 2021 census recorded a total of 70,900 Iran-born individuals residing in the country (Australian Bureau of Statistics (ABS), 2023). This figure represents an 18% increase in the Iranian community compared to the 2016 census, which indicated there were 58,112 Iranian-born individuals in Australia (Australian Government, 2018). Furthermore, the 2021 Census reported that 27,515 Iranian-born individuals were living in New South Wales (ABS, 2021), illustrating that Iranians constitute a significant portion of the state's population. This figure is more than double the number of Iranians (22,546) recorded in 2011, reflecting a 61.5% increase (Department of Home Affairs, 2016). Of the total migrants, approximately 22,550 have been residing in New South Wales (NSW) (ABS, 2021). Iranian migration to Australia has been largely driven by 'push' factors, including political, economic, and social instability that began with the revolution and continued throughout the war with Iraq (Matindoost, 2018). As a result, many Iranians have sought refuge in Australia over recent decades.

Recently, the primary origin countries of migrants included the United Kingdom, China, Malaysia, India, and Indonesia. However, recently, Iran has emerged as a significant source of skilled migrants, providing capable and talented individuals. We predict that 5,630 more Iranians will migrate to Australia in the fiscal year 2024 than those who emigrated from it. This figure indicates an increase in net foreign migration from Iran to Australia compared to the previous fiscal year (Statista Research Department, 2023). Various factors, including the political instability in Iran, have contributed to the influx of Iranian migrants in Australia. Following the 1979 Iranian

Revolution, Australia initiated a humanitarian program for Baha'i Iranians, resulting in the arrival of approximately 2,500 individuals in the 1980s (Farsight, 2015).

In addition to the humanitarian program, Australia provides a range of temporary migration programs and schemes, including sponsored labour migration, skilled migration programs, skilled nominated visas, regional skilled work visas, skilled independent visas, and state-nominated migration programs (Hosseini, 2016). Those who permanently migrated to Australia in 2021 through the visa stream included 1,761,000 skilled individuals (59%), 962,400 family members (32%), and 283,600 humanitarian individuals (9%) (ABS, 2023). Iranians who were admitted for family reunification, as well as professionals under the skilled migration program, began arriving in Australia in the late 1980s and early 1990s (Farsight, 2015).

Many Iranians are currently residing in Australia without valid visas; however, according to Farsight (2015), there is no significant evidence to estimate the number of individuals living in Australia without valid visas. Several factors can help explain this discrepancy. Compiling an annual record of irregular maritime arrivals (IMAs) and participants in humanitarian programs segmented by nationality poses challenges. One issue is that bureaucratic classifications shifted due to periodic changes in Australia's procedures for boat arrivals between 2007 and 2014, and government agencies altered the format and frequency of their reports (Farsight, 2015).

The Migration Act 1958 (Cth) stipulates that migrants and refugees who enter Australia without a valid visa and arrive on the mainland or in an "excised offshore place" are subject to immigration detention until they obtain a valid visa or are removed from Australia (Australian Human Rights Commission, 2010). The Department of Home Affairs detains individuals in both community detention and closed immigration detention, either onshore or offshore. This classification includes those who enter Australia as asylum seekers without a valid visa, as well as

individuals whose visas have been revoked for various reasons (Australian Human Rights Commission, 2010). In November 2011, the government announced that an increasing number of individuals in closed immigration detention centres would be considered for transfer to community detention or release into the community on bridging visas, following preliminary identity, security, and health checks. On November 21, 2012, the Australian government announced that, because of overcrowding in immigration detention centres and problems with facilities for asylum seekers in Nauru and Manus Island, some migrants and refugees who arrived at certain offshore locations on or after August 13, 2012, would be allowed to live in the Australian community on bridging visas.

3.3. Migrants' Experience of Mental Health Problems

3.3.1. International context

Mental health issues are increasingly recognised as a significant concern in Australia and globally, suggesting that action is needed to promote well-being and provide support for mental health, particularly due to the rising social and economic costs associated with psychological issues (Bhavsar et al., 2019). While the health and social challenges faced by migrants may not differ substantially from those encountered by the general population, individuals who have been forcibly displaced are at a heightened risk of experiencing mental health issues, exacerbated by various stressors that can adversely affect their well-being (Grasser, 2022). Most individuals affected by emergencies either witness or endure stress and trauma, which can encompass losing their homes and means of support, being separated from family members, and even experiencing abuse and torture (Vukčević Marković et al., 2023). Consequently, it is common for displaced individuals to experience significant levels of distress, which may manifest as transient issues

such as fatigue, irritability, anger, and feelings of despair, anxiety, and hopelessness (United Nations Office on Drugs and Crime (UNODC), 2020).

As evidenced by various systematic reviews and meta-analyses, migrants are at an increased risk of suffering from a range of mental health problems compared to the general population. This heightened risk is attributed to factors such as exposure to war, torture, violence, and forced migration, as well as the uncertainty surrounding their lives and status in their host country (Kirmayer et al., 2011; Mesa-Vieira et al., 2022). The prevalence of PTSD among migrants is reportedly up to ten times higher than that of the general population, alongside elevated rates of depression, chronic pain, and other psychiatric disorders (Kirmayer et al., 2011). Hocking et al. (2015) suggest that ongoing challenges, including isolation, distress, long-term unemployment, and loneliness, may induce anxiety and depression more significantly than recent life stressors. However, the risk of developing psychological issues can vary widely among individuals, influenced by personality traits such as a propensity to worry excessively, sensitivity to criticism, or tendencies towards self-criticism. In their 2015 study, Hocking and colleagues found that immigrants who are already vulnerable due to previous negative experiences or personal factors may face mental health issues triggered by a combination of stressors. The nature of these stressors differs from person to person; some individuals may struggle with living alone, while others may find challenges in cohabiting with many people. Furthermore, migrants are more likely to engage in substance use and develop drug use disorders. Research from various regions has demonstrated that migrants often resort to substances as coping strategies or forms of self-medication (Horyniak et al., 2016; Kirmayer et al., 2011). Long-term studies show that if mental health problems are not addressed, they can cause serious and lasting social and financial issues, such as problems in

personal relationships, fewer job opportunities, lower pay when working, and a higher chance of getting involved with the criminal justice system.

The prevalence of mental health issues and associated risks varies between immigrants and native-born citizens of destination countries, as well as between immigrants and their non-immigrant co-nationals. A study by Horyniak et al. (2016), which focused on forced migrants, reported prevalence rates of alcohol dependence ranging from 1% to 42%, while drug dependence varied from 1% to 20%. The authors noted significant variability in substance use patterns, which complicates the ability to draw definitive conclusions. This variability is likely influenced by multiple factors, including social norms and the local availability of substances. More importantly, stigma has been shown to affect the reporting of substance use in diverse cultural settings, which may occasionally result in a misrepresentation of actual prevalence rates (Horyniak et al., 2016).

Despite the variability in the prevalence of mental health issues and AOD use, it is clear that migrants face elevated risks of AOD consumption and are more likely to suffer from severe mental health problems (Horyniak, Melo, Farrell, Ojeda, & Strathdee, 2016). This situation may stem from various barriers that prevent migrants from accessing and utilising mental health services in their host countries. The literature extensively documents the barriers immigrants encounter when attempting to access mental health care (World Health Organisation [WHO], 2023).

These barriers include a lack of awareness about available services, difficulties with transportation and language, challenges in navigating the healthcare system, distrust, perceived stigma, differing perceptions of mental health, and, consequently, differing needs for care (Ahmed et al., 2016). A systematic review by Aggarwal et al. (2016) highlighted that healthcare providers often struggle to understand the cultural nuances of mental health issues, face communication

challenges with patients, and lack culturally appropriate services, all of which hinder treatment access or the continuation of counselling andmental health care. Furthermore, mental health specialists have been reported to stereotype and exhibit prejudice or discrimination towards migrants while providing services (Esses et al., 2021; Mladovsky et al., 2012). The lack of background information among health professionals concerning immigrants may exacerbate these issues and lead to dissatisfaction with the care received.

Researchers conducting a qualitative study in Canada aimed to explore the perspectives of healthcare professionals working with migrant clients about the availability and utilisation of mental health services, and they found that these migrant clients faced numerous barriers. These included communication difficulties, cultural perceptions of mental health, stigma surrounding mental health issues, and concerns about negative outcomes associated with living with mental health disorders. Additionally, healthcare professionals expressed feelings of inadequacy and a lack of appropriate training when dealing with immigrant clients in need of mental health support (Salami et al., 2019).

Inadequate mutual understanding and cultural disparities have been identified as key factors contributing to ineffective help-seeking and consultation with migrant clients at the Schengen border by healthcare practitioners. The authors emphasised that providing mental healthcare necessitates upholding human dignity, which cannot be compromised (Žagar et al., 2019).

3.3.2. The Australian Context

As this study focuses on the issues mentioned in Australia, I would like to share some reports and evidence concerning the impact of AOD in the country and the application of the harm reduction model in this context.

AOD pose significant public health challenges in Australia. In 2024, AOD use accounted for approximately 14% of the national disease burden, with alcohol, tobacco, and illicit drugs playing major roles in preventable illness and mortality (AIHW, 2025). In 2021, alcohol was linked to over 1,500 deaths and was responsible for more than half of drug-related hospitalisations (ADF, 2024). Over the past year, one in five Australians reported experiencing abuse or fear due to an individual under the influence of alcohol (ADF, 2024).

Australia addresses these issues through a harm minimisation framework, as outlined in the National Drug Strategy 2017–2026, which incorporates demand, supply, and harm reduction strategies (Department of Health, 2017). Key harm reduction strategies include needle and syringe programs, opioid treatment programs, supervised injecting facilities, and pill testing services, which have recently been expanded in Queensland (The Guardian, 2024). These interventions aim to reduce health risks, promote safer usage, and enhance access to treatment for individuals.

Research suggests that harm reduction policies in Australia are effective; however, challenges persist, such as stigma and inequalities in access (Australia21, 2023).

Recent research indicates that Iranian immigrants in Australia may encounter heightened mental health challenges, particularly in relation to acculturation stress. Hosseini et al. (2017) found that Iranian immigrants who were unemployed, younger, unmarried, or faced prejudice demonstrated increased levels of depression. Conversely, factors such as higher education and

moderate levels of acculturation were linked to better mental health outcomes. Additionally, studies have highlighted the complex experiences of Iranian male migrants, suggesting that substance use within this group is often tied to gendered expectations and the strains of migration. These findings point to the need for tailored mental health therapies that consider the unique experiences of Iranian immigrants in Australia. Such therapeutic approaches should address the psychological consequences of migration and integrate cultural sensitivities relevant to the Iranian community. By enhancing understanding of their specific challenges, mental health professionals can more effectively support this population in adjusting to their new environment while maintaining their cultural identity. Although no study has specifically investigated the experiences related to the co-occurrence of AOD consumption and mental health issues among Iranian male migrants in Australia, existing evidence suggests that Iranian migrants face mental health challenges alongside social and emotional difficulties that adversely affect their lives (Green & Latifi, 2021).

Furthermore, recent studies indicated that the grief of separation, in addition to other distressing experiences such as discrimination, poorly planned migration processes, and not being welcomed by the host community, can have a significant impact on the immigrants' wellbeing (Anikeeva et al., 2010; Mwanri et al., 2022). The experience of mental health problems can be impacted by waiting for long periods to be processed and/or provided with visas. Sometimes, migrants in Australia may even wait a long time in detention centres or UN refugee camps. These situations may in turn cause distress and other mental health problems such as anxiety, hopelessness, fatigue, and sleeplessness among the migrants (Anikeeva et al., 2010; Silove & Mares, 2018).

A study by Rostami et al. (2022) found that parents of asylum-seeking children and teenagers, who had psychosocial problems, showed more signs of post-traumatic stress disorder (PTSD) when they lived in communities with few services and rights for a long time. The results suggest a compounding situation for asylum families, in which parents' PTSD is, in one way or another, linked to their children's psychosocial difficulties, particularly in contexts of insecure residency (Rostami et al., 2022).

3.4. Cultural Differences Between Iran and Australia

Although the Australian culture has been reported to be multi-dimensional owing to the increased immigration from different countries (Pham et al., 2021), cultural differences between Iran and Australia are present. Iran frequently orients societal norms and values on group cohesion and sustaining social bonds, resulting in a collectivist culture (Zmmt, 2023). The emphasis is on indirect communication, which relies on implicit clues and body language to transmit meaning. In contrast, individualism prevails in Australian culture, with a higher emphasis on direct and explicit self-expression, as well as on individual rights and autonomy. This philosophy is frequently reflected in communication approaches, with Australians being more inclined to express their ideas and demands clearly, without depending on nonverbal signs (Evason, 2021).

The idea that different cultures can be categorised as either vertically patterned or horizontally patterned is a concept that highlights fundamental differences in social organisation and communication styles (Hosseini, 2016). In vertically patterned cultures, there is a clear hierarchy, and individuals are considered to be distinct from one another. In contrast, horizontally patterned cultures view individuals at the same level (Gelfand & Holcombe, 1998). Communication styles in Australia are characterised by more individualistic horizontal patterns,

which can pose significant challenges and cause substantial stress for Iranian immigrants (Hosseini, 2016). This shift can create tension for Iranian immigrants, who may feel torn between their cultural values and the new values they are encountering in Australia (Gelfand & Holcombe, 1998; Hosseini, 2016).

As immigrants face challenges adjusting to a new culture, they often experience trauma that can affect their sense of self and identity. This trauma is commonly referred to as a "trauma story" and is a defining aspect of the refugee experience (Grazer, 2023; Mondal, 2022). For instance, Iranian refugees in Australia may suffer from cultural trauma due to the stigmatisation they face, which can further aggravate their feelings of displacement. Regardless of whether they arrived as immigrants or refugees, displacement itself can be a significant source of trauma for Iranians (Aidani, 2010; Wylie et al., 2018). The Refugee Council of Australia (2019) noted that many individuals from refugee families have undergone suffering, trauma, and significant losses prior to arriving in Australia. As a result, these humanitarian entrants may present with various emotional, psychological, and physical health challenges (Refugee Council of Australia, 2019). They may have gone through different traumatic incidents, including torture, persecution, civil conflict, abductions, sexual abuse, bereavement, hunger, and disease (Refugee Council of Australia, 2019). Research indicates that approximately three-quarters of humanitarian and refugee arrivals in Australia have experienced trauma and torture prior to their arrival (Australian Institute of Health and Welfare, 2023; Coffey et al., 2010; Ellis et al., 2008). Refugees may have prolonged stays in refugee camps or transit countries, which can significantly impact their ability to adjust to a new environment. Studies indicate that a considerable proportion of adult refugees resettled in Western countries suffer from mental health issues (Patanè et al., 2022).

It is essential to acknowledge the resilience and hope that refugees possess in addition to their challenges. While addressing the difficulties and traumas faced by refugees is crucial, it is also equally important to recognise and support their resilience and positive attributes (Ghazinour, 2003). Although the symptoms of post-traumatic stress can differ across cultures, there is compelling cross-cultural and historical evidence indicating that exposure to intense traumatic situations can lead to significant psychological discomfort (Muldoon et al., 2019). Nevertheless, such responses are not inevitable, and there is increasing awareness that traumatic experiences do not always result in negative psychological outcomes. Notably, some traumatised groups demonstrate resilience and exhibit post-traumatic growth as a response to extreme traumas (Muldoon et al., 2019).

The experience of mental health problems by migrants can be significantly impacted by a migrant or refugee's gender and age of migration, as well as by the opportunities and difficulties associated with settling down. Although some studies indicate that mental health issues are more prevalent among youth migrants, such as Mwaniri & Mude (2021), estimates by ABS show that the prevalence is even higher among men aged between 25 and 44 years (Green & Lalifi, 2022).

While there are some studies addressing AOD use and mental health issues among immigrants in Australia, none have specifically focused on the co-occurrence of mental health problems and AOD use among Iranian migrant men. Although some research has investigated mental health issues among Iranian migrants, such as the study by Hosseini (2016), there has been no examination of co-morbid AOD use. Furthermore, Hosseini's study was quantitative and concentrated on the prevalence of psychosocial problems among migrants. There exists a significant knowledge gap regarding the interplay between mental health problems and AOD use among Iranian migrants. Additionally, no studies have captured the experiences, perspectives, and

views of these migrants themselves, particularly concerning their interactions with therapeutic services in the face of cultural and discrimination barriers. This thesis represents a crucial endeavour to explore mental health challenges and AOD use based on the lived experiences of Iranian migrant men in Australia.

3.5. Summary

The introduction chapter of the thesis offers an in-depth breakdown of the relevant literature related to the objectives of the research, focusing on migration trends in Australia, mental health issues among migrants, and migrants' interaction with counselling services. It highlights the significant influx of Iranian migrants to Australia over the past few decades, driven by political, economic, and social factors in Iran. The chapter also discusses the challenges faced by migrants in accessing mental health services, including cultural differences, stigma, and communication barriers.

The section on migrants' experiences with mental health problems explores the international context by emphasising the higher prevalence of mental health issues among forcibly displaced individuals. It discusses the impact of trauma, stress, and uncertainty on migrants' mental well-being, as well as the increased risk of substance use disorders among migrants. The Australian context section analyses the specific challenges faced by Iranian migrants in Australia, such as acculturation stress, discrimination, and prolonged waiting periods for visas.

The chapter also highlights the cultural differences between Iran and Australia, particularly the shift from a collectivist culture in Iran to an individualistic culture in Australia. The chapter emphasises the importance of understanding cultural differences when providing effective mental health services to Iranian migrants. The research aims to address the gap in existing studies by

exploring the co-occurrence of mental health problems and substance use disorders among Iranian migrant men in Australia, with a focus on their experiences and interactions with therapeutic services.

4. Theorical Framework

4.1. Introduction

In this chapter, I present a comprehensive description of the theoretical framework employed in this dissertation. Theory is fundamental to scholarly work, serving various purposes. It aids in the formulation, development, and direction of research questions. Additionally, it helps researchers determine the types of data they will collect and facilitates the interpretation and analysis of findings, as well as the explanation of the phenomena under investigation (Giles & Harrison, 2023). The primary theoretical frameworks utilised include social constructivist theory and feminist theory. The subsequent paragraphs will discuss these two theories in detail.

4.2. Social Constructivist theory

According to Tom (2012), the concept of social constructionism has been in existence for over three decades and originated within the discipline of sociology. The theoretical framework known as social constructivism, also referred to as interpretivism, is associated with the postmodern era, particularly in the context of qualitative research (Tom, 2012). Social constructivists assert that knowledge and truth arise from the social interactions among members of a given society (Tom, 2012). Shared systems of understanding, primarily through spoken or written languages, convey global narratives. We understand these narratives as reflections of interactions among individuals, rather than as external assertions made by the researcher based on their internal thoughts.

Social constructionism helps us look closely at how society's rules, cultural stories, and power relationships influence how we define and respond to AOD use and mental health problems

in migrant communities. This perspective challenges the notion of universal objective truths concerning mental health and substance use, highlighting that these issues are influenced by social processes and discourses.

A recent research investigation draws attention to stigma as a social construct that significantly influences migrants' experiences with alcohol and other drug use and mental health. A systematic review by Douglass et al. (2022) demonstrates that stigma, shaped by ethnicity, gender, and citizenship status, serves as an impediment to obtaining support for mental health issues and alcohol and other drug use among migrant and ethnic minority populations. The research highlights how dominant discourses and social structures sustain stigma, obstructing individuals from pursuing essential care and support.

A study by Horyniak et al. (2023) similarly investigates the stigma related to AOD usage within migrant and ethnic minority populations. The research indicates that stigma diminishes access to help and overlaps with other social factors, resulting in intricate barriers to care. The study underscores that the obstacles encountered by migrants in obtaining mental health and AOD services are not solely personal concerns but are fundamentally rooted in societal constructs and institutional practices.

These findings demonstrate how social constructionism elucidates the influence of societal attitudes and institutional actions on the experiences of migrants confronting AOD use and mental health issues. By acknowledging the constructed character of these difficulties, there exists an opportunity to promote more inclusive, culturally sensitive, and equitable care practices that tackle the fundamental social variables impacting migrant communities.

This study adopted a social constructionist perspective, with a particular emphasis on language and social customs. The philosophical viewpoint regarding this question advocates a relativist ontology, suggesting that reality is shaped by human cognition and that there is no singular objective reality. Instead, reality is dependent on the subjective experiences of individuals situated within specific temporal and spatial contexts (Moon & Blackman, 2014).

From an epistemological perspective, constructionism posits that the notion of uncovering an objective truth is illusory. Instead, the creation of "truth" or meaning is reliant on our interactions with the realities that exist in our world (Moon & Blackman, 2014). Hiller (2016) proposes a transactional and subjective view of knowledge. The relationship between the researcher and the subjects of study is mutually influential, with discoveries emerging through the investigative process rather than being pre-existing in the environment and awaiting discovery (Hiller, 2016).

In line with Willig's (2013) categorisation of social constructionist approaches that range from radical to moderate, my position aligns more closely with the moderate end of the spectrum, characterised by a lesser degree of relativism. I aim to tentatively establish correlations between the discursive construction of a localised reality and the broader sociocultural context in which it takes place. Willig (2013) recognises the significance of broader cultural, political, institutional, and other occurrences in discussions of research interactions.

It is essential to emphasise the core concepts of the theory and clarify how they pertain to the mental health and AOD experiences of migrants in order to effectively examine social constructivism as the theoretical foundation of this dissertation. Language, norms, conventions, experiences, and discourses are all social constructs. The language surrounding forced migration highlights that these constructs are not always benign (de Ruiter, 2017; Kapur, 2018).

Social constructivism is a prevalent theoretical paradigm across various research disciplines, including discussions of integration. It acknowledges the influence of culture, language, and historical context on individuals' perceptions, beliefs, and behaviours (Berger & Luckmann, 2023). Furthermore, social constructivism provides an advantageous lens for investigating immigrant integration and social cohesion, which are, in various ways, connected to the mental health challenges faced by Iranian immigrants in Australia (Byrne & García Lázaro, 2023).

4.3. Feminist Approach

Feminism is part of critical theory, which seeks to destabilise systems of power and oppression (Arinder, 2020). It aims to conceptualise gender roles and incorporate women's interests into social organisations. A feminist method involves analysing people's experiences from a political viewpoint with a focus on sex as a major lens (Lorraine Radtke, 2017). Feminist theories encompass the theoretical and philosophical analysis of the concept of feminism. Broadly speaking, feminist theoretical frameworks focus on the examination of gender-based disparities and delve into topics pertaining to the societal fabrication of gendered norms and associated forms of inequity (Usmani et al., 2023).

Feminist theory is characterised by a focus on several thematic areas, such as gender-based discrimination, sexual objectification, oppression, patriarchy, and stereotyping (Srivastava et al., 2017). These topics have been explored in various scholarly works, including those by Paasonen et al. (2020) and Wrisley (2021). Shinde (2020) argues that contemporary feminists must strive to promote literate and civil democracies. He further asserts that it is imperative to resist authoritarian regimes and ideologies that suppress the freedom and entitlements of individuals, particularly

women. Feminist frameworks are founded on a broad position opposing discrimination and gender-based oppression, with a specific focus on the oppression experienced by women (Shinde, 2020).

Feminist research is a type of analysis that seeks to discover and criticise the ways in which hegemonic, patriarchal systems of dominance affect entire communities (McLewis et al., 2023).

Feminist theory has traditionally been categorised into three distinct waves. The initial wave was mostly spearheaded by Western, cisgender, white, middle-class women, concentrating on legal rights like suffrage. The second wave, which gained traction in the 1960s and 1970s, broadened the feminist agenda to incorporate perspectives from women of colour and those from underdeveloped nations, who contested the narrow focus of prior campaigning. The third wave, which arose in the 1990s, was partially a reaction to the perceived shortcomings of the second wave. It has frequently been criticised for its absence of a cohesive agenda and for being perceived more as an extension than a divergence from the second wave (Molyneux, Razavi, & Thompson, 2021).

The feminist perspective on power has significantly contributed to our understanding of the interconnected and interdependent systems of subjugation, particularly through the concept of 'intersectionality' as proposed by Crenshaw (1989) (Collins et al., 2021). This concept has faced considerable criticism, with some critics labelling it a "buzzword" (Davis, 2008).

Such a label risks oversimplifying and standardising the concept, which is problematic when addressing social divisions like "gender," "race," and "class." These categories are ontologically distinct and necessitate careful differentiation (Yuval-Davis, 2006). Nevertheless, it

is crucial to acknowledge that the lived experiences of oppression arising from the intersection of these categories are both valid and tangible (Carstensen-Egwuom, 2014).

Gender analysis in migration studies emerged in the 1970s and early 1980s, initially focusing on individual-level factors. By the mid- and late-1980s, feminist migration scholars shifted their focus from merely researching women to examining gender as a system of interactions influenced by migration (Nawyn, 2010). Feminist theories have progressed in elucidating the reasons behind varying migration patterns among individuals. According to Honda-Sotelo and Cranford (2006), this line of research is grounded in sex role theory, which posits that gender is a fixed category that affects migration behaviours. Feminist migration researchers have connected gendered expectations to macro-structural pressures and the agency of both men and women (Nawyn, 2010).

Feminist theories contend that the distress experienced by both women and men can be attributed to sex-based and gender-based social and structural constraints, as well as resource deficits that interact with other limitations (Frazer & Hutchings, 2020). However, despite the emergence of various waves of feminist theory, the majority has been articulated from a Western perspective, often prioritising the experiences of white Western women (Molyneux et al., 2021).

4.4. Role of Social Divisions

According to Yuval-Davis (2006), social divisions are defined by distinctive power dynamics and emotional connections among individuals who operate either informally or as representatives of specific social institutions and organisations. These divisions are instrumental in shaping patterns of inclusion and exclusion, discrimination, and disadvantage, as well as influencing particular aspirations and identities (Yuval-Davis, 2006). Furthermore, social

stratification is often legitimised through the attribution of biological essentialist characteristics, which define what is considered "normal" or "abnormal" and determine which individuals qualify for access to specific resources (Yuval Davis, 2006).

Stamarski and Son Hing (2015) contend that culture and structure are interdependent processes that defy mutual exclusion. They further claim that organisational practices, policies, and procedures may reveal gender disparities. The sources mentioned (Davis, 2008) explore the interconnected relationship between gender and power. Understanding power dynamics and their perpetuation in social interactions is a critical component of the feminist analysis of oppression and the development of alternative societal models (Benschop, 2021).

There exists a divergence of opinion among feminist thinkers regarding the notion of "human nature": some argue that a theory of human nature is essential to underpin progressive political aspirations, while others maintain that human nature is a construct that has historically been employed to justify social hierarchies (Antony, 2022). Despite these disagreements, feminist theory provides a valuable framework for understanding human behaviour in society by contextualising the experiences and challenges faced by female counsellors (Lay & Daley, 2007). The primary aim is to highlight the intrinsic value of women and challenge the institutionalised biases they encounter due to their gender (Llorens et al., 2021).

According to Enns (2021), employing a feminist theoretical framework allows analysts to explore the various forms of oppression that intersect within the socio-political, economic, ethnic, and cultural contexts that affect individuals, groups, families, and organisations. This framework focuses on identifying the variables that define the environment of the entity in question—be it an individual, group, family, or organization—and its interactions, which can lead to the emergence of oppressive circumstances (Enns, 2021).

The general populace often associates feminist theory predominantly with women's rights; however, Wrisley (2021) argues that it does not sufficiently address the prejudice faced by women. Even though there is a lot of feminist research looking at how sexism affects society, culture, politics, and institutions, the ideas that come from these studies are often incomplete, confusing, or inconsistent (Wrisley, 2021).

This research utilises a feminist theoretical framework to clarify the underlying factors contributing to the disproportionate incidence of violence, discrimination, and oppression experienced by women who provide counselling services to men dealing with mental health issues and AOD consumption. By focussing on gender and power, feminist theory serves as a critical lens for understanding the relationship between violence against women and counselling. It emphasises notions of power and control and is considered an inclusive theory, as it highlights the dynamics of power systems and the oppression experienced by both men and women (Dekel et al., 2019). Furthermore, as Taylor (2019) notes, the feminist theoretical framework, when examined from a broader perspective, actively challenges the tendency to depict women's experiences with violence through the lens of victim blaming (Taylor, 2019).

While it is recognised that achieving any equilibrium will take time, there is a strong belief that effective gender concepts aimed at modifying societal norms must acknowledge diversity, plurality, and individuality. These concepts are influenced not only by gender but also by factors such as age, race, sexual orientation, religion, culture, and socioeconomic status (Madanda, 2023). Similarly, Ferguson (2017) asserts that feminist theory has become an expansive, productive, and diverse intellectual and political assemblage. It evolves through innovative interdisciplinary work and critical political engagement. The evidence indicates that feminist theory includes a multitude

of perspectives and definitions rather than adhering to a singular framework under the broad umbrella of feminism.

Feminist theory initially focused on women but has since evolved to encompass minority and marginalised communities, including immigrants. As previously mentioned, feminism serves as a theoretical framework designed to challenge the existing patriarchal system and the associated social injustices that lead to the devaluation of women and other marginalised groups (Pompeo-Fargnoli, 2018). Following the initial wave of feminism, which achieved women's suffrage through the suffragette movement, feminist discourse became dominated by what are often referred to as the "big three" feminist approaches (Pompeo-Fargnoli, 2018). These approaches include liberal, radical, and socialist/Marxist perspectives. While all these viewpoints aim to make those in power responsible for issues related to gender inequality, discrimination, and violence, supporters of each perspective have different ideas about what causes these inequalities (Aranda, 2017; Morrow, 2005). The third phase of feminist discourse places significant emphasis on intersectionality and the experiences of oppressed groups (Kovach, 2021). Moreover, third- and fourth-wave feminists strive to understand the cumulative impact of oppression on individuals who identify as queer or have racialised ethnic backgrounds. The core goal of eradicating oppressive forces remains central to feminism, which has expanded to include discussions on power and discrimination (Kovach, 2021).

Despite its primary focus on women and minority equality, some scholars have applied feminist theory to real-world cases concerning immigration justice (Higgins, 2017). A feminist approach to immigrant admission examines social institutions, including existing or proposed immigration policies, and evaluates whether these assign unfair social benefits and burdens based on gender (Higgins, 2017). However, Higgins (2017) questions whether a feminist approach to a

country's immigration policies can be confined to gender alone, as it must also take into account other forms of social identity. Recognising the importance of gender considerations in immigrant admissions renders it illogical to overlook other social identities. Alongside gender, factors such as race and economic class are also critically relevant to immigrant admission in various societies, including Australia, which is the focus of this thesis (Higgins, 2017). As a migrant from Iran—where cultural norms often regard women as inferior and limit their ability to undertake roles such as counselling—the application of feminist theory is essential. It can illuminate the potential impact of the culture of migrants' countries of origin on their participation in the counselling profession. This discussion is significant for understanding how one's cultural background may influence the experiences of discrimination faced by female counsellors in the host country, particularly in the autoethnography phase of the study.

As highlighted in the literature review, certain migration policies in Australia, such as the mandatory detention of immigrants and refugees, may significantly affect the mental health of Iranian migrants. This, in turn, could lead these migrants to engage in the misuse of illicit substances. While feminist theory has demonstrated its effectiveness as a research approach within the social sciences, it does have certain limitations. Firstly, this theory struggles to fully recognise the different factors that help explain violence against women and the ways migrant women cope with it (Norlock, 2019). Feminist frameworks have developed to include early feminist theories and provide a comprehensive analysis of numerous factors, including religion, race, minority status, and other intersecting elements (Yick, 2001; Norlock, 2019). This approach facilitates an in-depth examination of the coping mechanisms utilised by women who are required to work alongside men from similar cultural backgrounds. Theories that emphasise self-determination, empowerment, and autonomy for women may conflict with the values and beliefs of women from

cultural backgrounds that prioritise men's welfare over that of women (Yick, 2001; Franklin & Menaker, 2014).

4.5. Summary

This chapter has provided a comprehensive discussion of the theoretical framework employed in the paper. Key theories that are essential for this study include social construction theory and feminist theory. Social constructivist theory posits that knowledge and truth are products of social interactions among members of a particular society. The argument suggests that knowledge and 'truth' in this context arise from the interaction between the researcher and the study subjects. Consequently, the researcher will acquire a deeper appreciation for migrants' experiences, including their engagement with illicit substances such as alcohol and opium, among others. Furthermore, social constructivist theory will offer ideas about how migrant status influences the mental health of Iranian migrants.

Furthermore, scholars have explored feminist theory. Originally centred on women's empowerment, the theory has significantly evolved over the years, with various waves redefining its focus to include issues pertaining to minority groups, stereotypes, discrimination, and gender identity. While feminist theory primarily addresses gender, it has been argued that achieving societal norms must consider a range of factors such as age, race, sexual orientation, religion, culture, socioeconomic status, and various other elements. Additionally, feminist theory encompasses different approaches, including liberal, radical, and socialist/Marxist perspectives. The application of feminism to immigration policies renders this theory particularly relevant for this paper. Therefore, it is essential to examine the experiences of Iranian migrants, particularly in relation to their mental health challenges and the factors that may worsen these difficulties.

5. Qualitative Interview Methodology

5.1. Introduction

This chapter provides a comprehensive overview of the methods and approaches used to achieve the aims of this study. Mental health issues, the consumption of AOD, and migration are significant disruptive events in individuals' lives. Consequently, striving to understand the meanings and explore the lived experiences of Iranian migrants is particularly relevant to this study. Specifically, the research adopts a qualitative methodology that draws upon theoretical foundations to inform and guide the exploration of research questions while also seeking to elucidate the meanings that individuals attach to health and social issues. As noted by Creswell and Poth (2016), this approach aids the researcher in generating knowledge. Therefore, in this chapter, I will discuss the qualitative methodology, along with its underlying philosophy and research approaches. Additional subtopics covered will include the research paradigm, philosophy, research design, recruitment process, and the measures taken to ensure ethical practices in relation to data collection and analysis.

5.2. Research Paradigm

A research paradigm is the philosophical foundation on which a researcher bases their research. It provides a set of beliefs and understandings that underpin one's research project's theories and activities. Denzin and Lincoln (2005), as mentioned in Levers (2013), describe a paradigm as the researcher’s "net" that includes beliefs about what exists, how we know things, and how we study them, and they call the basic, unquestioned parts of a paradigm "first principles,

or ultimates" (p. 183). Paradigms are important because they influence decision-making processes and research practices.

Unlike ontology, which pertains to the fundamental nature of existence and the structure and essence of the world, the field of epistemology concerns itself with the study of knowledge and the relationship between the individual seeking knowledge and the object of knowledge (Sol & Heng, 2022). The ontological perspective that an individual holds has a significant impact on their epistemological beliefs regarding the nature of knowledge. Consequently, these factors will influence the researcher's perception of the appropriate techniques to employ to gain knowledge about the world, which is commonly referred to as the research methodology.

Epistemology refers to what is known to be true, and it is significant because it determines how scholars frame their study in their effort to obtain knowledge. The key types of epistemologies are subjectivism, objectivism, and constructionism (Al-Ababneh, 2020). Subjectivism implies that we can derive meaning from the object we attribute it to. This means that the subject imposes meaning on an object and that the object itself makes no significant contribution to the meaning derived (Al-Ababneh, 2020). In this case, the object refers to the study participants, whereas subject refers to the researcher (or the person conducting the study). On the other hand, objectivism means that meaning exists within an object. This viewpoint implies that an objective reality is present amidst an object independent of the subject, and it represents “the position that social entities exist in reality external to social actors” (Saunders et al., 2009: p.110). Constructionism entails the meaning that stems from the interaction between the subject and objects. Constructionist epistemology denies the notion that objective 'truth' exists and is ready to be revealed. Rather, 'truth' or meaning emerges from interactions with the researcher's surroundings. This means that the 'real world' does not exist in isolation from human action or symbolic communication. The

significance of constructionist research is in generating contextual understandings of a certain topic or problem (Moon & Blackman, 2017).

Since the goal of this study is to explore the mental health experiences of Iranian men and their interaction with AOD, as well as how these factors relate to their migrant status, I will adopt a constructionist epistemology. This approach posits that meaning can only be constructed through direct engagement with the study participants, allowing for a more profound understanding of their mental health experiences and AOD consumption.

5.3. Interpretive Phenomenological Approach

For this research, I have chosen the phenomenological approach as proposed by Van Manen and Adams (2011). Phenomenological inquiry focuses on understanding and interpreting the lived experiences of individuals (Smith et al., 2009). In contrast to positivism, phenomenology (or interpretivism) is a theoretical framework that aims to comprehend and elucidate human and societal realities. This philosophical methodology, initially described by Husserl, seeks to account for lived experiences in their terms, rather than through pre-existing theoretical frameworks (Smith & Osborn, 2015).

The phenomenological approach recognises that research is inherently interpretative, as humans are creatures who seek to make sense of their experiences (Smith & Osborn, 2015). According to Husserl, phenomenological inquiry facilitates an understanding of experiences as they exist in the consciousness of individuals. He introduced the concept of "intentionality" to illustrate the connection between consciousness and the objects of attention (Smith et al., 2009), linking it to the characteristics of individual conscious experiences (Walsh, 2017). This method enables a thorough analysis of lived experiences and investigates the phenomenon in question.

I selected this research paradigm because it allows participants to articulate their detailed experiences, encompassing thoughts, images, memories, and feelings. This approach is particularly suitable for this research project, as it offers information about the perceptions and understandings of Iranian forced migrant men who have relocated to Australia and are facing issues related to AOD and mental health. Furthermore, this approach is reportedly consistent with autoethnography.

In particular, I intend to use the interpretive phenomenology approach, which is related to social constructionist theory since both grew from hermeneutic philosophy (Bush et al., 2019). The interpretive method seeks to identify historically and culturally grounded interpretations of the social life setting. The interpretivist philosophy generates meaning in a unique manner by focusing on subjective and descriptive approaches to address complex circumstances rather than relying on objective and statistical approaches (Al-Ababneh, 2020). The use of this interpretive framework has demonstrated its utility in the context of phenomenological research investigations.

The core idea of an interpretive phenomenological study is about understanding the more profound meaning of experiences, where particular examples help us grasp the complexity of an event. This form of inquiry tries to address inner experiences that remain unexamined in everyday life (Merriam & Greiner, 2019). Essentially, the researcher focuses on the meanings individuals attach to various experiences in the context of the phenomenon (Creswell, 2013). It will facilitate the research participants to provide a comprehensive and unrestrained account of their personal experiences.

5.4. Research Design

The research question is essential in determining the study design since it specifies the type of information required and the methods for its collection. A clearly articulated research question facilitates the identification of the research's qualitative, quantitative, or mixed-methods nature, along with the most successful tactics and sampling methodologies. By examining the connection between a subject and an object, we can investigate the concept of epistemology and how it impacts study design (Moon & Blackman, 2017).

Effective research design involves translating research questions into projects. Research design determines research methodologies, strategies, and samples. There are four sorts of research designs based on the goal of the study: exploratory, descriptive, emancipatory, and explanatory (Al-Ababneh, 2020). Exploratory studies aim to investigate, ask questions, gain new insights, and generate suggestions for future research. Robson (2002) cited in Al-Ababneh (2020) defines exploratory studies as flexible designs. Exploratory studies are undertaken when there is limited or no prior knowledge of similar research methods, and they provide greater knowledge of the phenomena being studied. Compared to an exploratory study, a descriptive study seeks to provide a vivid profile of an event, situation or individuals, whereas an exploratory study seeks to explain a phenomenon being studied or a situation, but it does not have to be a causal relationship (Al-Ababneh, 2020). Based on the nature of this study, I resolved to using the exploratory study since the issues being studied have never been studied before, and there is even no information available about the mental health experiences of Iranian male migrants living in Australia.

Exploratory research has strengths such as researcher discretion. This lack of structure in exploratory research allows the researcher to direct the research process, providing a great deal of

freedom and flexibility. However, exploratory studies are subject to certain limitations. One of the limitations of this study design is that it brings up tentative results that are reportedly inconclusive. Since the focus of the research design is to capture and formulate an insightful comprehension of the experiences of participants being studied, the study insights may not be reliable for effective decision-making. Moreover, given the qualitative nature of the data used in exploratory research, it is challenging to get accurate insights that can be summarised objectively. Moreover, the small number of participants involved in an exploratory study design augments the risk of the participants' responses being unrepresentative of the general population (Thomas & Lawal, 2020).

5.5. Research Methods

In this thesis, I resolve to use a qualitative multi-method approach. Unlike mixed methods, a multi-method approach in qualitative research involves combining two or more qualitative approaches to study a research subject or phenomenon (Roller & Lavrakas, 2015). Because of the additional data collection and analysis issues, qualitative multi-method research could drain key resources such as time and available study finances. However, this isn't always true, and under the right circumstances, using several qualitative methods can greatly enhance the researcher's understanding of the topic compared to using just one method. In this case, the qualitative methods of data collection used include in-depth focus group interviews with Iranian forced migrant men and autoethnography. Focus group discussions with participants will support the autoethnography research approach.

5.5.1. Research Site

The study was conducted at the Drug and Alcohol Multicultural Education Centre (DAMEC). DAMEC is a non-governmental organisation that focuses on minimising the harm that

comes with AOD in communities that are culturally and linguistically diverse (CaLD). It was working towards reducing the impact and harm of AOD usage. The organisation worked extensively for the betterment of culturally and linguistically diverse communities in New South Wales. This organisation provides counselling and therapeutic services to alcohol- and drug-addicted people.

5.5.2. Recruitment of participants

Purposive recruitment, or purposive sampling, is a non-probability sample method frequently employed in qualitative research, wherein participants are deliberately chosen based on particular traits or expertise that correspond with the research aims. Instead of pursuing a statistically representative sample, purposeful recruitment targets individuals capable of offering profound, pertinent, and varied insights into the topic under investigation (Palinkas et al., 2015). Researchers exercise discernment to select participants who are most likely to provide significant insights into the research topics, typically due to their experiences, responsibilities, or opinions. This study employed a purposeful recruitment technique to ensure that participants, specifically Iranian forced migrant men, possessed relevant lived experience pertaining to the research objective. This methodology enabled me to obtain comprehensive data from individuals whose perspectives helped clarify the intricacies of displacement, identity, and mental health and AOD issues, which may not have been obtained using random sampling methods.

To consider the issues mentioned, I adopted a purposeful recruitment strategy to identify individuals who could freely and willingly provide the information needed to address the research question. To make sure the participants gave trustworthy information for the study, I used a specific selection method that involved finding and recruiting a small group of people who clearly represent a particular category (Palinkas et al., 2015). The participants were Iranian men who migrated to

Australia in the last one to 10 years and aged 18 years and above. Current and former clients of DAMEC who had received or were receiving support for AOD usage and other mental health issues were approached to participate in the research. A total of thirty participants who were attending counselling sessions at DAMEC offered to participate in this study voluntarily. We also recruited participants from the Iranian Narcotics Anonymous (NA) group in Sydney. An additional five participants from the NA group joined the study through snowballing.

5.5.3. Data Collection

Before I began the data collection exercise, I developed an interview guide based on the literature review. In collaboration with DAMEC's Farsi-speaking peer research officer, Mr Ahmad Jadaran, we further revisited the interview guide to ascertain that the questions were easy to understand and pertinent to participants' lived experiences. The final version of the interview guide included open-ended questions about participants' experiences with mental health and AOD issues, as well as their interactions with mental health services. For this research study, I used in-depth focus group interviews guided by a diverse set of questions outlined in the questionnaire (see Appendix 1). It assisted in gathering a detailed account of the life experiences of the interviewee (Brinkmann et al., 2008). When presenting extremely sensitive information, open-ended questions not only reduce the impact of bias but also promote in-depth learning and the exploration of speculative explanations for observed links (Friborg & Rosenvinge, 2013). Researchers can also change the order and wording of questions to make it easier for participants (Kallio et al., 2016). We also refer to these interviews as conversations with a specific structure and goal (Miles & Gilbert, 2005). Miles & Gilbert (2005) stated that the in-depth focus group interviews allow the building of rapport between the researcher and the participants.

Interviews were scheduled based on the preferences and convenience of the participants. The interviews were conducted at the locations preferred by the participants, even though they ultimately took place at DAMEC. Each interview took approximately 2 hours. I conducted the in-depth focus group interviews in person. Participants were asked to start the interview by discussing their background, age, sex, and other relevant demographic details, like where they came from and how they got to Australia. I asked follow-up questions and tried to go in-depth based on the answers of the participants. I captured the responses from the participants by taking notes. In addition, recording was applied but only after seeking permission from the participants. After each interview, we took time to share our reflections. After finishing interviews, I came to a consensus that the data collection process was complete, and it was sufficient to answer the research questions or meet the study aims.

5.5.4. Interview Procedure

To prepare the participants in advance, I developed the participant information statement (refer to Appendix 2) alongside the consent form (see Appendix 3). The research program received approval from the University of Sydney's Human Research Ethics Committee (USYD). Prior to commencing interviews, each participant reviewed and signed the consent form (refer to Appendix 3). I reached out to every participant to arrange an interview time that suited them. Most participants confirmed their availability and were able to attend DAMEC for the interviews. I made arrangements in DAMEC’s group room to facilitate the interviews.

To protect the interviewees' privacy and avoid interruptions, only the interviewer and interviewee were allowed in the interview room. After informing the participants about the study, I provided them with an information sheet outlining the study's purpose and the questions that would be posed during the interview. Participants were informed of the interview's benefits, risks,

duration, and any follow-up needed, and they confirmed their eligibility by reviewing the informed consent.

I encouraged participants to voice any questions or concerns they had. Before the interview commenced, I addressed these queries to ensure the participants felt comfortable and understood the purpose of the questions.

I conducted in-person interviews in Farsi since all participants could speak the language fluently. Additionally, I encouraged participants to speak openly and freely in sharing their lived experience. If participants were reluctant or unable to share their experience, I would rephrase questions to assist in their engagement. At the end of the interviews, participants were provided with a list of different organisations if they required additional support in case the interview caused them stress.

5.5.5. Data Analysis

To achieve the aims of this study, the analysis of the collected data was done through inductive thematic analysis since it was based on the descriptions made by the participants regarding their experiences. Inductive thematic analysis is a qualitative data analysis approach that entails gathering and analysing data in the absence of predetermined categories. Such flexibility enables the collected data to guide the researcher and identify emerging themes and patterns. I transcribed both the interview responses and the recorded audio verbatim to initiate the data analysis process.

I analysed the transcripts using the six-step guide proposed by Braun and Clarke, which is a critical framework for analysing qualitative data. The six steps in Braun & Clarke's model are as follows:

1. Familiarisation with the Data: In this step, I pertain to reading the collected data multiple times to identify themes or patterns. Additionally, I transcribed the collected data, made notes, and rechecked it for accuracy. I analysed the content to identify key themes and essential sections. I selected quotes that represent varied perspectives and patterns relevant to the research aims.

2. Generating initial codes: It involves organising the data in a systematic and meaningful manner. Coding is an important process that helps cut down large chunks of data into small and manageable codes of meaning. I used open coding, which means that I did not establish pre-set codes, but rather I developed and modified the codes throughout the coding process. As Braun and Clarke (2006) underscored, analysing the entire dataset is crucial for identifying patterns and developing themes. I selected relevant keywords from quotations as keywords clear the path for forthcoming code development and data interpretation and enhance the depth and quality of the analysis covered in the following sections of this study.

3. Generating initial emergent codes: This step involves examining the codes to identify existing themes. A theme in the research work is defined as a patterned response or meaning (Braun & Clarke, 2006, p. 82). They are developed by grouping the codes. Different codes are grouped together to form a theme. Some of them constitute a major theme, others are subthemes, and some are not used at later stages (Braun & Clarke, 2006). This stage transforms complex textual material into a theoretical form and helps find relevant elements for research questions. Keywords are crucial in coding, serving as the foundation for analysis and transforming raw data into meaningful units. In this case, the keywords used included "stress," "anxiety," "depression," "PTSD," and other terms that indicated the mental health experiences of the participants. Other keywords used include alcohol, drugs, illicit substances, and any other word that denotes AOD consumption. The emergent codes are represented in (See Appendix 6).

4. Reviewing Themes: In this step, all the developed themes were reviewed and further grouped with the other themes, which eventually results in the development of new themes. The themes which are closely related are merged. I reviewed the themes to make them fit according to the data set and aligned them in a way that can help in answering the research questions (Braun & Clarke, 2006). The themes generated are presented in (See Appendix 6).

5. Defining the Themes: This phase involves the final refinement of the themes, and its purpose is to '…identify the essence of what each theme is about' (Braun & Clarke, 2006, p. 92). Conceptualisation entails identifying and characterising emerging concepts based on data. I identified and defined social patterns relevant to this research. The quality of these definitions is evaluated for clarity, accuracy, reliability, applicability, and relevance to theory and practice.

6. Report Writing: Report writing refers to the presentation of the themes coherently and logically in the results chapter. It describes the data as well as makes arguments about the research.

5.5.6. Ethical Considerations

The National Health and Medical Research Council (NHMRC) website is one of the common resources for learning about ethical research protocols in Australia. It is an essential place to begin learning about the ethical review process because it gives straightforward guidance and recommendations for researchers and ethics committee members. According to the National Statement, ethical conduct during research is based on the principles of justice, merit, beneficence, and respect (National Health and Medical Research Council, 2023).

Before the data collection commenced, the study procedure and the consent form for in-person interviews were approved by the Human Research Ethics Committee of the University of Sydney. I shared all required information related to informed consent with participants. Moreover,

I shared with the participants the nature and purpose of the research through a Participant Information Sheet (see Appendix 2).

As a researcher, I showed respect to all participants by acknowledging their right to autonomy. In this regard, before the interviews started, I sought consent from each participant by explaining to them in the Farsi language what the study entails. Each participant signed the consent form to show that they agreed to participate voluntarily. I assured the participants that they will not be disadvantaged by participating in the study and that failure to participate would not lead to any repercussions and they would continue to receive services as usual. Further, I was aware of being respectful toward participants and avoiding asking certain questions. I focused extensively on the word selection and avoided language that could be seen as stigmatising. These include words such as *na-mard,* which depicts a man as not being brave enough to face and/or overcome life challenges. Participants were also informed about the safety protocols established for them, and a list of support services was provided if they became distressed or upset during or after the interview (see Appendix 4).

I made it clear to the participants that there was no coercion involved in their participation. I displayed a poster on the DAMEC reception wall to recruit potential participants (see Appendix 5). I ensured that the research maintained the anonymity and confidentiality of the participants. No personal information was collected or recorded during the interviews. Instead of using the participants' real names, we assigned each participant a unique code for identification purposes. In the final report, no details regarding participants' names, addresses, locations, or places of residence were presented. This approach protected participants' confidentiality and rendered it impossible to trace them. I assured the participants that the data collected would solely be used for the study and would never be shared with third parties. The digital copies of the data were stored

on a password-protected computer, while physical copies were secured in a locked filing cabinet, accessible only to my assistant and me.

A crucial aspect of ethical consideration relates to my dual role as a researcher and a counsellor working with the participants. In this regard, I ensured that my role as a researcher was distinctly separate from mine as a counsellor at DAMEC. Even for those participants with whom I had previously interacted while providing counselling services, I ensured that their names were not disclosed during the focus group discussions. I assured the participants that any information shared would be kept confidential and would not affect their services at DAMEC. Participants recruited through DAMEC, with whom I had prior contact, might have felt compelled or pressured to participate in this study. Such pressure could lead to reluctance to participate or a hesitance to share their experiences as migrants living in Australia. To guarantee that every participant was free to engage voluntarily in the study, I employed several strategies. First, I clearly communicated that my current role was that of a researcher, not a counsellor. Secondly, I provided the participants with a participant information sheet for their review. Before commencing the focus group discussion, participants had the opportunity to read and sign the consent form. Should any participants express concerns or misunderstandings regarding the Participant Information Sheet, I clarified the content in straightforward language.

5.5.7. Trustworthiness

Researchers can establish the reliability of their studies and reporting by employing specific methods. According to Lincoln and Guba (1985), as cited in Stahl and King (2020), there are four key factors that determine trustworthiness: credibility, transferability, dependability, and confirmability.

Credibility

Credibility entails asking about the extent to which the findings are congruent with reality. With credibility, this research seeks to comprehend how reported findings hang together, implying that the ideas ought to have some relationship with each other (Stahl & King, 2020). Various approaches can enhance the credibility of study findings. However, in this study, I implemented member checking. The procedure involved transcribing all interview responses and then providing a copy of the write-up to each participant to ensure the accuracy of the data. I combined notes and audio recordings because capturing every detail during the process can be challenging.

Transferability

Although a qualitative research design does not prioritise replicability, I ensured that the patterns and descriptions derived from my study methodology could be applied to other studies or contexts. I carefully adhered to a qualitative study design and its underlying philosophies to facilitate potential replication in future research. This approach enhanced the impact of my study, enabling scholars and researchers to draw insights from its extensions and further their investigation into the experiences of immigrants and the challenges they face. Additionally, I aimed to provide a detailed description of my methodology and findings to support a nuanced interpretation of the circumstances that may be relevant to the work of other researchers.

Dependability

To ensure the reliability of my thesis, particularly concerning methodology and data accuracy, I engaged an external researcher who was not involved in either the data collection or the data analysis to review both the data collection and analysis processes, as well as the results of the dissertation. This engagement helped confirm the accuracy of the study findings and ensured

that the results are substantiated by the collected data. I exchanged my interview notes with Mr Ahmad Jadaran, and we all reviewed and responded to each other's notes. In the event of inconsistencies, we discussed the issues until we reached a consensus. Differences in opinion were addressed by exploring the areas of disagreement, relying more heavily on existing literature related to the topic under study. Mr Ahmad Jadaran understands and speaks Farsi and possesses significant experience working with migrants who face mental health issues and substance use problems. Such characteristics further enhanced the reliability and credibility of this study.

Confirmability

Trustworthiness can be viewed through the lens of confirmability, which entails striving to approach objective reality as closely as possible within qualitative research. In this context, rather than constructing reality within my findings, I relied on the concepts of accuracy and precision employed in the research practices of other scholars, such as Green and Latifi (2022).

Reflexivity

The reflexivity approach to trustworthiness is closely linked to confirmability. In this context, I incorporated a reflexive element into the research project by maintaining a journal, which enhanced the findings derived from conducting interviews with participants. During these interviews, sentiments of frustration, sadness, and confusion were evident.

Fleet et al. (2016) note that when discussing sensitive topics, the boundaries between the researcher and participants can become blurred. While some researchers contest the importance of these boundaries (Kitchener et al., 1998), others regard them as an ethical obligation, referring to this concept as "role fluency" (Casemore, 2009; Fleet et al., 2016). I felt a heightened sense of responsibility to be clear and transparent in my writing (Ortlipp, 2008).

The use of reflective journals enabled me to document decisions related to the chosen methodology (Meyer & Willis, 2019) and to reflect on insights gained throughout the research process (Lincoln & Guba, 1985). This reflexive process encouraged me to examine my own assumptions, leading to a more thoughtful, nuanced, and critical interpretation of the collected data.

This aspect was particularly significant, as I am a migrant from Iran. Although my migration experience differs from that of most forced migrant Iranian men participating in this study, I recognised the potential for subjectivity due to my personal views and experiences as a migrant.

5.6. Chapter Summary

The chapter provides a comprehensive description of the methodology adopted in this study, focusing primarily on the qualitative research approach. Researchers find that a qualitative research model, based on constructivist theory, which encourages reflection on their work and the research processes, is the best way to carry out this research project. Additionally, I discussed both philosophical stances and the overall paradigm of the study. Furthermore, I outlined the methods of data collection, which involved conducting one-to-one interviews with study participants. Data analysis utilised the model proposed by Braun and Clarke (2006), which encompasses transcribing interview notes and audio recordings, coding, organising themes, identifying themes, reviewing themes, and report writing.

Other subtopics addressed in this chapter include ethical considerations, such as authorisation from the university's ethics committee, obtaining consent, ensuring confidentiality,

and safeguarding participants from any potential harm or risk associated with the interview process.

Lastly, the chapter examined concerns regarding trustworthiness, including credibility, transferability, confirmability, dependability, and reflexivity. I elaborated on each of these trustworthiness concerns in qualitative research, detailing the approaches and processes I employed to ensure the overall quality and trustworthiness of the study findings.

Chapter seven presents the results, detailing the participants' experiences with mental health, AOD issues, as well as their interactions with mental health services in the country and the challenges they encountered in accessing and utilising counselling services from various organisations.

6. Autoethnography Methodology

6.1. Introduction

In addition to qualitative analysis of Iranian men migrants' experiences of mental health and AOD issues through focus group interviews, I intend to include in this study an account of my experiences in relation to working with Iranian migrants living in Australia to address the mental health issues and AOD issues. I intend to use autoethnography to explore the experiences of migrant Iranian men regarding mental health and AOD experiences and how they interact with the Australian mental health services and providers.

In this section, I provide a detailed description and evaluation of autoethnography methodology as it relates to this study, including its definition and rationale.

6.2. What is Autoethnography?

The term autoethnography is clearly presented and defined by three autoethnography scholars, Carolyn Ellis, Tony E. Adams, and Arthur P. Bochner, in their seminal work, Forum: Qualitative Social Research, 121(1) 2011. Autoethnography: An overview. The authors state that "Autoethnography is an approach to research and writing that seeks to describe and systematically analyse (graphy) personal experiences (auto) to understand cultural experience (ethno) (Ellis et al., 2011).

The researchers use tenets of autobiography and ethnography to do and write autoethnography, as this method allows them to weave their personal narratives into broader cultural contexts, thereby giving them deeper understandings of social phenomena.

By blending subjective experiences with analytical frameworks, autoethnography offers a unique lens through which to explore and interpret the complexities of human behaviour and societal norms. Thus, as a method, autoethnography is both a process and a product." (p. 1). Because of its roots in anthropology and ethnography, autoethnography questions traditional research methods by viewing the research project as a way to tell stories instead of just explaining theories.

Anthropologist Heidgger first introduced the term autoethnography in 1975. He portrayed the research participant as an autonomous individual rather than as the ethnographer who examines the culture and experiences of others. Over the years, autoethnography has significantly evolved, and today it represents the autoethnographer's interconnectedness with themselves and the subjects they intend to study.

As explained by Nagy Hesse-Biber (2017), autoethnography, as a research method, enables researchers to use their own thoughts, experiences, emotions, and even feelings as data to help them comprehend the social world. This type of research can be empowering on the part of the researcher-subject and help elevate an individual's reflexivity and consciousness (Nagy Hesse-Biber, 2017).

While autoethnography is evocative in the sense that it offers a pathway for gaining access to one's feelings and emotions, a researcher can also evaluate autoethnographic data with the aim of gaining insight into the wider societal factors that are reflected in one's evocative autoethnographic data. In relation to this, Wright Mills once stated that 'personal troubles are often symptomatic of public issues' (Nagy Hesse-Biber, 2017).

Autoethnography is inherently a qualitative methodology, comprising intricate and specific insights into life experiences and their connections with others (Allen et al., 2015). It facilitates a more profound understanding of cultural experiences (Ellis et al., 2011).

Specifically, autoethnography can be described as a genre of writing and research akin to autobiography, as it involves a consciousness that links personal experiences to cultural contexts (Bochner & Ellis, 2016). However, autoethnography is not simplistic. It is not only related to the story's description; it is also followed by the inquiry by adopting a social-scientific approach and the interpretation of the data collected from the respondents (Chang, 2008).

Adams and Manning (2015) further employed this approach to explore personal experiences within political, cultural, and social contexts. The central focus of autoethnography lies in the researcher's personal experiences, which are examined further to discover more about the culture.

This methodology fosters a holistic perspective on both the writing and research process as well as the interpretation of findings in relation to social, political, and cultural factors (Ellis et al., 2011). Such research highlights the personal experiences of the researcher, which arise from their involvement in society or from possessing a specific cultural identity (Ellis et al., 2011).

The intent behind adopting this approach is to derive meaningful and impactful findings that can resonate with a diverse audience, encouraging their engagement in fostering social change (Ellis et al., 2011). Moreover, this approach prompts researchers to reassess their thinking, perceptions, societal relationships, and methodologies to ensure the generation of reliable findings (Jones et al., 2016).

Researchers utilise the ethnographic method to document and analyse their personal experiences, thereby improving one's understanding of cultural experiences (Ellis, 2004; Ellis et al., 2011; Jones et al., 2016). This approach assists researchers in identifying universal aspects of life within the experiences they accumulate over time. Through their writings and interpretations, researchers provide readers with the opportunity to learn from their lived experiences (Ellis, 2004; Ellis et al., 2011).

Despite its numerous advantages for both researchers and readers, the autoethnographic approach to research remains less prevalent than other methodologies, even though it has been acknowledged since the 1980s (Ellis et al., 2011). Doty (2010) asserts, "The presence of self is obvious in academic writing in its absence." This absence possesses a power that enables researchers to present their work, grounded in lived experiences, as authoritative, neutral, and objective (Doty, 2010).

Owing to this fact, the influence of the researcher is visible in this research work because the topic of the research is related to her personal experience and interest. This research approach has gained recognition because the presence of the researcher is inevitable in her work (Doty, 2010). Additionally, many scholars have begun to question the limitations of traditional research approaches due to the diversity in values, language, mindset, writing styles, interpretations, and other factors influenced by race, gender, education, class, age, and various demographic characteristics (Ellis et al., 2011).

Autoethnography recognises the uniqueness of individual personalities and the complexity of life. Autoethnography has expanded upon other research methods due to its innovative ways of knowing (Ellis et al., 2011).

As a researcher, I believe that the autoethnographic approach is most suited to my topic, as it can facilitate the achievement of my research aims and objectives (Ellis et al., 2011). As indicated by the autoethnographic triad developed by Ellis and Bochner, as cited in Chang (2008), autoethnography consists of three components: auto (self), ethno (culture), and graphy (research process).

The research process, or the act of conducting autoethnography, involves identifying and exploring an 'epiphany'—an occurrence that can significantly transform the researcher's life—while applying theoretical and methodological tools in conjunction with relevant research literature. Moreover, the research process in autoethnography also entails exploring an event within its cultural context while examining the experiences of others, comparing and contrasting these experiences to identify patterns within qualitative study approaches (Adams et al., 2017). In addition to conducting autoethnography, researchers employing this method also engage in writing, which is essential for producing outcomes from the autoethnographic research process. Writing autoethnography involves (i) creating an aesthetic and evocative text that captivates readers by employing storytelling conventions; (ii) 'showing', which invites a 'being there' perspective through rich descriptions; and (iii) 'telling about', which establishes a distance and creates space for readers to reflect (Adams et al., 2017).

Researchers who utilise autoethnography actively write about their experiences in cultural and social contexts to illuminate the complexities of the population's socio-cultural lives and practices (Poulos, 2021). Similar to autobiography, creative nonfiction, and memoir, autoethnography relies heavily on writing as a fundamental aspect of research and serves as a primary method of inquiry. This suggests that autoethnographers harness the insights gained

through the writing process, treating writing as a research approach that drives inquiry rather than merely serving as a means of articulating findings post-research (Poulos, 2021).

There are different forms of autoethnography available that vary depending on the purpose of the study, and scholars such as Ellis et al. (2011) have identified more than 40 forms of autoethnography. However, I cannot list and describe all these forms of autoethnography here. For the purpose of this study, I chose the narrative ethnography, which I will discuss in detail in the following paragraphs.

6.3. Narrative Autoethnography

Narrative autoethnography is a method of storytelling that intertwines the personal experiences of researchers with their observations of others (Ellis et al., 2011). As a subset of autoethnography, narrative autoethnography emerged in the early 1980s as a research approach that generates evocative, meaningful, and accessible findings rooted in personal experiences (Méndez, 2013). In this thesis, I chose to employ narrative autoethnography to identify and evoke personal ‘epiphanies’ while also understanding often-overlooked experiences that resonate with readers.

This research method enabled a deep contemplation of my personal experiences, which involved a thorough examination of personal diaries and photographs taken while providing care for Iranian migrants in Australia who were facing mental health challenges and issues related to AOD. Specifically, for the purpose of this thesis, I reflected on my experiences, beginning with my migration from Iran approximately 11 years ago and my life in Australia while engaging with migrants who were receiving treatment and counselling services for mental health and AOD issues.

The data generated through narrating my life and experiences, which emerged from the intersections of gender, ethnicity, race, citizenship, and nationality, prompted questions and insights regarding my migration journey. This exploration of the diverse facets of my life has fostered a greater understanding of the migration experience while also illuminating the dynamics of power and privilege associated with my intersecting identities. Consequently, this study is rooted in a reflective examination of personal experience and addresses the topic of migration in a comprehensive manner.

Researchers employing narrative autoethnography delineate numerous benefits and advantages of this approach. A notable strength, as emphasised by Farrell et al. (2015), is that narrative autoethnography enables researchers to engage in profound, reflective storytelling while critically assessing their cultural identities and personal experiences. Farrell et al. emphasised that this method is particularly effective for analysing the intersection of individual experiences and overarching social, political, and cultural frameworks. From this perspective, personal narratives are not merely isolated or subjective; they function as analytical instruments that uncover profound insights regarding identity, power, and belonging. The ability to integrate personal reflection with academic studies renders narrative autoethnography an effective approach to examining intricate human experiences, especially in situations of marginalisation, migration, or cultural hybridity.

Richard (2008) similarly examined the benefits of narrative autoethnography, especially its capacity to promote emancipatory discourse. This approach can enable both researchers and readers by providing narratives that connect personally, thereby fostering thought, empathy, and social consciousness. Richard further asserted that autoethnographers can reclaim authorship over their experiences by "representing themselves" instead of being colonised by others, subjected to their agendas, or relegated to the role of "second-class citizens" (p. 1724). Narrative

autoethnography is a valuable method for exploring human relationships and identity formation in multicultural societies, as autoethnographers assume the dual role of storyteller and analyst, interpreting their emotions, actions, and social positioning.

Autoethnography involves organising and transforming personal memories into data (Ellis et al.,2011). According to Pavlenko (2007), narrative serves as a literary instrument that enables ethnographers to share knowledge and create data-driven stories. Teame (2020) employed narrative autoethnography to explore the lived experiences of women in East Africa, Canada, and Qatar. This approach emphasises the importance of time by focussing on the narrator's personal experiences instead of taking a detached perspective on historical events (McMaken, 2013).

For this research, I examined the work of counsellors who provide intercultural counselling to Iranian men who have forcibly migrated to Australia. Although other research methods could have been suitable for this study, I selected autoethnography for three specific reasons:

1. This research approach is modern and unique.

2. It allows me to incorporate my personal experiences into the research.

3. As an immigrant in Australia, I possess an understanding of the challenges and hardships faced by migrants. I believe this approach is particularly fitting for my research as it offers an opportunity to illustrate my lived experiences.

6.4. Rationale of Autoethnography

Adams et al. (2017) explain that autoethnography enables researchers to share their personal narratives to challenge or expand upon prevalent cultural stereotypes and narratives while simultaneously demonstrating their understanding of their own cultural experiences. Additionally,

autoethnography facilitates the narration of everyday moments that may be difficult to articulate or capture through conventional research methods. Furthermore, Adams et al. (2017) assert that autoethnography is a suitable research approach for producing texts that are accessible to a broader audience, including those outside the academic sphere. This method begins with the writer's life experiences and extends to encompass culture, discourse, and ideology while also addressing injustices and advocating for the voiceless. (Zapata Sepúlveda, 2017).

In this thesis, autoethnography has been instrumental in articulating the various social groups to which I belong, how individuals respond to me, and how these responses influence my experiences of power and privilege. Smith's (2005) analysis of narrative autoethnography supports my choice of this method. According to Smith (2005), as cited in Chuang (2015), “Autoethnography allowed my personal experiences to become valid data…. Autoethnography freed me to write reflectively, thoughtfully, and introspectively about a very personal subject close to my heart” (Smith, 2005, p. 73; Chuang, 2015). In this thesis, I have incorporated a first-person narrative of my experiences in Australia, as well as shared my personal encounters that highlight the privileges I have gained in my new country of residence, which starkly contrasts with my previous experiences in Iran.

6.5. Autoethnography and Research Design

Although autoethnography occupies the most important part in this study, the research design adopted in this thesis is an autoethnography combined with external validation of interviews of participants. External validation means using outside information to confirm that the findings and insights from autoethnography are trustworthy and applicable (Weis & Willems, 2016). One qualitative research method that can be used to support the validity of the reflections,

explorations, and discoveries made by the autoethnographer is the use of focus group interviews (Ellis et al., 2011).

The ethnographic researchers may use interviews as a research technique to validate autoethnographic results by examining, discovering, and reflecting on the comparisons and differences in interview responses. Integrating interviews into autoethnographic research allows for the exploration of shared cultural narratives, enhancing the depth and validity of the study. As noted by Ellis, Adams, and Bochner (2011), interviews can serve to engage with other narratives, providing a broader context to the researcher's personal experiences. This approach not only enriches the data but also facilitates external validation by comparing and contrasting individual accounts with those of others within the same cultural setting. In this thesis, I used focus group discussions (FGDs), where participants answered open-ended questions to share more information, tell their stories, and provide clarifications, which helped me with the autoethnographic analysis.

6.5.1. Data Collection

Autoethnographers often gather information using methods and tools akin to those employed in other qualitative social research, such as participant observation, interviews, conversations, focus groups, narrative analysis, artefact analysis, archival research, journaling, field notes, thematic analysis, description, context, interpretation, and storytelling (Poulos, 2021). They then craft compelling narratives that aim to evoke and encapsulate the researcher’s lived experiences in relation to the phenomenon being investigated (Poulos, 2021). This narrative autoethnography drew upon personal memories that encompassed a range of challenging, joyful, and raw experiences. In keeping with the autoethnographic approach, I relied significantly on personal recollection as a primary source of data.

I took the time to write down stories that narrated my experiences of working in Australia, particularly with Iranian migrants facing mental health and AOD issues. My stories served as data that were closely examined to understand the context of my narratives within the lives of Iranian migrant men residing in Australia. This method enabled me to gain insights into the complex contextual features of their lived experiences.

I expanded the data collection process by compiling relevant diaries, photographs, and letters that I accumulated during my time in Iran, throughout my studies in Australia, and while working with Iranian migrants at DAMEC. These artefacts provide additional layers to my reflections on past experiences that have influenced my understanding of migration and the immigrant experience in a foreign country.

As previously mentioned, I used FGDs to enhance my autoethnographic narratives regarding my experiences as a female counsellor working with Iranian immigrant men in Australia. The FGD comprised ten participants, all of whom had also taken part in individual interviews during the initial phase of my study. This number of participants was deemed suitable, as various researchers suggest that a group size of four to twelve is ideal (Muijeen et al., 2020). We informed the participants in advance about their involvement in the FGD. During the individual interviews, I primarily communicated and encouraged their participation in the FGD. I arranged for a room at DAMEC to conduct the discussions. After obtaining consent from all participants and explaining the significance of interviewing them a second time, we commenced the focus group discussions. I requested permission to record the sessions using an audio recorder while I took notes during the FGD.

6.5.2. Data Analysis (Autoethnography)

For this research, I have selected thematic analysis (TA) to analyse and interpret the experiences gained from interacting with Iranian men who are forced to receive counselling and psychotherapy for their mental health and AOD issues. TA relates to the content of the story, including aspects such as what happened, how it occurred, who was involved, and for what purpose (Riessman & Quinney, 2005; Riessman & Speedy, 2007). You can think of TA as a catch-all word for a variety of qualitative analytic methodologies. The three basic techniques of TA are coding reliability, codebook, and reflexive (Braun & Clarke, 2019). TA has been frequently used in contemporary qualitative health research designs, such as studies conducted by Lyng et al. (2022) and Opsomer et al. (2019), since it is not bound by a specific methodology and is remarkably flexible.

Given that my study is based on the social constructionist theoretical framework, I chose to use reflexive thematic analysis. A social constructivist or an interpretive approach to qualitative research supports a transactional approach to inquiry where the researcher has a personal interaction with the study subjects (Zelčāne & Pipere, 2023). Out of the various forms of TA approaches, reflective TA is appropriately aligned with the paradigm of social constructivism since it stresses the active role played by the researcher in coding and generating themes. The researcher is not only involved in the identification of semantic themes and summarising the data content but also identifies covert themes in order to divulge the underlying ideas within the data (Braun & Clarke, 2019). In such a case, the subjectivity of the researcher is the underlying ‘instrument’ for reflexive thematic analysis, which is considered as a resource for research rather than a problem to be addressed (Braun & Clarke, 2019). The mentioned inquiry focuses on how participants, together with the researcher, perceive and interpret their subjective experiences, rather than on the

objective reality. It should also be emphasised that researchers' previous experiences, biases, and research positions influence how they view data. Subjectivity without reflexivity may be a constraint, but if the researcher understands his/her function and impact, subjectivity can become an essential resource (Zelčāne & Pipere, 2023).

In this thesis, I was an insider to the participants involved in the FGD while conducting the discussions. My personal experience of being an immigrant from Iran and having worked in counselling and providing treatment to Iranian immigrant men living in Australia who had experienced mental health issues and consumed AOD helped stimulate a dialogue with the participants and build a trusting environment.

This approach proved to be beneficial for my work because the content of the stories, which is derived from the experiences and memories of the researchers, focusses on what participants experienced. From this vast experience, the researchers collect various stories and apply different themes to them (Riessman & Quinney, 2005). This approach focuses on the content of the stories or narratives collected by the researchers through different means, like written documents or conversations generated from conducting interviews (Riessman & Speedy, 2007).

To collect and analyse data for this study, I first sought ethical approval and spoke with my supervisors, friends and family. Using autoethnography, I categorise and review my memories while documenting academic exchanges between myself and supervisory committee members. Ellis et al. (2011) suggest that the analytic outcome of research should not just reflect literature and autoethnographic methods but also inspire others to have epiphanies. Therefore, cultural awareness regarding one's relationships with others is crucial for analysis.

The process culminated in creating a list of experiences I gained over five years while working with clients at DAMEC. I then developed a list of themes. I then organised and analysed these themes for my own inventory. The developed themes and the writing supported me in selecting the useable information and discarding the irrelevant ones.

For this research, I developed the themes based on my experience gained during my work at DAMEC. The major parts of the list include gender discrimination, breaching professional boundaries, flirting, cultural differences, confidentiality, and the anger of the clients. All these factors were associated with my professional experience. I ranked the themes based on their importance and then organised them into the narrative fit that best suited the autobiographical timelines. I developed these themes through extensive reflexive writing exercises.

Adams et al. (2015) recommend the utilisation of a narrative approach that fosters emotional engagement from both the writer and the readers. The significance of actively participating in the activities of editing and rewriting is emphasised by Adams et al. It is crucial for the creation of a story that possesses both coherence and significance. The approach outlined above enhances an autoethnographer's understanding of an individual's narrative (Adams et al., 2015). To fulfil the research purpose, address the research queries, and uphold the principles of autoethnography, two analytical approaches were utilised. I initially crafted the narrative with meticulous attention to detail, using specific extracts from my autoethnographic writing prompts. The diligent upkeep of a carefully crafted journal enhanced my understanding of professional experiences and assisted in the examination of facts. Furthermore, I conducted an analysis and interpretation of cultural data by employing psychosocial and developmental frameworks to examine my professional encounters as a bilingual counsellor specialising in alcohol and substance addiction.

I utilised two autoethnographic writing exercises to record my experiences with Iranian migrant men who were facing challenges related to AOD use and mental health issues. These interactions took place while I was working as a bilingual counsellor at AOD & Mental Health Treatment Services.

The writing exercises are based on Chang's (2013) theoretical framework, which emphasises the act of chronicling historical events and self-reflection. (Chang, 2013). According to Chang (2013), the practice of chronicling is a valuable method that entails organising information collected from memory in a sequential manner. In Chang's (2013) study, it is noted that autoethnographers possess the capacity to compile a comprehensive collection of topics. These themes are then organised and evaluated to effectively ease the process of self-inventorying. The preliminary stage of analysis and interpretation occurs when the autoethnographer undertakes the task of choosing and prioritising particular bits of material while simultaneously rejecting others, guided by a hierarchy of importance (Chang, 2013). Further, Chang (2013) posits that the autoethnographer possesses the capacity to construct an autobiographical chronology through the use of a sequential catalogue of noteworthy events or experiences.

After completing each draft of analytical writing, I detangled and arranged new facts based on my personal experiences. This method helped me have a more profound awareness of race, gender, ethnicity, and nationality, which I did not have before. Additionally, I re-evaluated my previous understanding using cultural perspectives, which enhanced the research analysis. Instead of focusing on my experience as an Iranian immigrant, I investigated similar experiences from my current middle-upper-class life in Australia. Shifting my story provided a new perspective that I had previously overlooked due to preconceived notions about the experience. Viewing my narrations and stories as data helped me dissect my interpretation of each encounter and challenge

the categories that influenced my frames of reference. Through a reflexive, rigorous, and iterative process, I gained a more profound understanding of how interconnected identities and social groupings impact migrant experiences. We transcribed the participants' responses and the audio recording verbatim for the FGD after listening to it several times.

The transcribed responses were then analysed using a thematic narrative analysis technique. I followed and used the classic six-step process suggested by Braun & Clarke (2006), which entails 1) familiarising oneself with the data, 2) generating codes, 3) constructing themes, 4) reviewing potential themes, 5) defining and naming themes, and 6) producing the report. I progressively went through the data several times until I was able to create the final themes.

6.5.3. Ethical Consideration (Autoethnography)

While this section of my study focuses on my personal experiences, it also encompasses stories about my family that shed some light on their relationships. According to Ellis et al. (2011), "using personal experience, autoethnographers not only implicate themselves with their work but also close, intimate others" (p. 8).

Thus, it is necessary to address relational ethics. In the context of autoethnography, relational ethics pertains to the conscientious representation of other individuals who are mentioned in the research. Furthermore, relational ethics demands that I take action with my heart and mind while acknowledging my interpersonal relationships with my close relatives (Ellis, 2007).

It is vital for me to be respectful of the relationship I have created as a researcher while simultaneously recognising and providing space for my roles as friends, daughters, and sisters.

I am unable to remain anonymous in this study, so I must address my relationships with friends, family, and Iranian clients. I have presented stories from my recollections, but it's difficult to tell stories without involving others; my experiences don't exist in isolation.

When it comes to ethical considerations, representing others becomes more difficult when the relationships under consideration are unpleasant or hostile. Sharing their work with the participants allows autoethnographers to address relational ethical issues (Ellis, 2007).

Before conducting the FGD, I sought consent from the participants. I also informed the participants that I would use an audio recorder to record their responses. Just like in individual interviews, I assigned pseudonyms to all participants instead of their real names. The pseudonyms used were those used in individual interviews.

6.6. Limitations and Scope

This research project is subject to certain limitations. Some of these limitations are in my control, while the others are beyond my scope.

The first limitation pertains to the researcher's willingness to share her experiences, emotions, and thoughts with others. As a researcher, it is my responsibility to keep a balance between keeping my personal and clients' information confidential while providing true and honest experiences and words (Méndez, 2013).

Another limitation of this research project is the single case. It does not apply to all types of cases. My counselling experience is limited to forced Iranian migrant men, so this research cannot be generalised to all kinds of counselling cases (Ellis et al., 2011).

Autoethnography is not associated with generalisability; it is the readers, not the respondents, who determine whether the narrative speaks about their experience or is associated with an unfamiliar culture. While reviewing the research work, readers compare its narrative to their own experiences and determine whether it aligns with those. They also analyse the feelings and emotions expressed in the researcher's work and then respond to them (Ellis et al., 2011).

Furthermore, due to the scope of this research project, I have limited the narration of my experience to the specified time. However, I have narrated my dynamics in working with the clients and shared the experiences that have impacted my physical as well as mental health and work experience. Another limitation of this research project is the excessive dependence on memory and journal notes.

Occasionally, it is challenging to completely and accurately recall the events and experiences, so the chances of distortion are there (Mendez, 2013). Yet, this limitation will not reduce the value of the autoethnography research approach, as it provides the opportunity for the readers to learn from the experiences of others (Mendez, 2013).

6.7. Responses and Criticism on Autoethnography

Autoethnography has encountered significant criticism in the academic sphere, especially from researchers who contend that the methodology is "egocentric" and "self-indulgent" because of its focus on the researcher's personal experiences (Maguire, 2006). These criticisms frequently originate in conventional positivist frameworks that emphasise objectivity and separation between the researcher and the topic. Researchers addressing emotionally charged subjects may find this critique particularly arduous, as revealing personal anguish within an academic framework is inherently vulnerable and taxing. Maguire (2006) asserts that the emotional

labour necessary for true autoethnographic labour is considerable, and allegations of self-indulgence frequently disregard the ethical and epistemological validity of lived experience as a legitimate means of knowledge production. Utilising an autoethnographic methodology for this research has enhanced my understanding of the issue and my role in it. This strategy has enabled individuals to connect with the work on a personal level by using their experiences and views to foster collective insight. Consequently, I contend that autoethnography, rather than being self-centred, promotes connection, empathy, and mutual understanding, thereby establishing it as a deeply humane research methodology (Maguire, 2006).

Some critics argue that autoethnography is not entirely reliable because researchers may not accurately and honestly present their experiences (Mendez, 2013). Knowing this fact, the researcher has already acknowledged this shortcoming in the limitations of the researcher. It is not possible to completely narrate the experience word by word with accurate feelings and emotions (Mendez, 2013). Due to the subjective nature of the experience, the researcher has tried to interpret the data and develop the connection between me and my experience to depict the social as well as cultural context relevant to the experience (Mendez, 2013) completely and accurately.

6.8. Implications of Research Findings

My autoethnography aims to immerse readers in my experiences while working at DAMEC. As a bilingual AOD counsellor, I offer insights into the cultural and social perspectives relevant to the research topic. The findings of this research align with its objectives, as they explore the impact of working with forced-migrated Iranian men facing issues related to AOD and mental health and reflecting on my experiences as a counsellor. Additionally, these findings will contribute to the existing literature on the subject.

6.9. Summary

This chapter outlines the methodology I have adopted, which is autoethnography. By employing this approach, I have also become the subject of the research, as it centres around a portrayal of my personal work experiences. The data collection for the autoethnography component of this research is derived from my memories and photographs, as well as from my personal journals and diaries, in which I have documented my observations during counselling sessions with Iranian men who have been forced to migrate and are grappling with issues related to AOD and mental health.

A literature review on counselling will follow this chapter, providing a thorough overview of working with these forced-migrating Iranian men.

7. Results

In this chapter, I will first describe the data analysis approach I used, followed by an explanation of IPA data analysis. Then, I will discuss the overall data analysis, including quotes and insights shared by participants about their experiences during the focus group interviews. This process will provide a comprehensive understanding of the themes that emerged, highlighting the richness of the participants' narratives.

7.1. Pre-Analysis Work

After collecting data from the participants using individual focus group interviews, I embarked on pre-analysis work which involved transcribing the recorded responses and field notes verbatim. With transcription, I typed all the interviews after listening to the recordings. I was responsible for translating transcripts from Farsi to English.

To protect and safeguard the participants' privacy, I provided pseudonyms for all the participants to replace their real names. In this respect, the participant's name was replaced by another name, which was determined randomly, alphabetically, or by assigning them some common names in Iranian culture. In addition, all notes and transcripts were then de-identified and cleaned, and the use of pseudonyms was incorporated. In the next step, I immersed myself in the gathered data, becoming familiar with and gaining cognizance of its content. I read the interview details multiple times to develop a preliminary understanding of the material. In the initial coding phase, I identified specific segments of the data and coded them inductively. It supported breaking down the data into manageable, smaller parts. The major segments included forced migration, mental health, AOD, and counselling, which aligned with the study goals.

In the next step, I began organising relevant codes into broader categories for data coding. The main purpose was to highlight the higher-level concepts and themes that emerged from the data. In this case, it included a history of drug use, immigration detention, loneliness in a foreign country, mental well-being, and managing addiction. This step encompassed multiple cycles of coding and categorization. I read the data numerous times to refine present categories, merge, or add categories to enhance understanding of the content. However, I ensured coherence and consistency in the categorization procedure by comparing data within and across different categories.

I repeated the process until I reached the saturation point where new data did not carry substantial alterations to the present categories.

7.2. Analysis of Primary Data

I used the IPA method to analyse the primary data. IPA is a qualitative research method that affords a researcher an opportunity to comprehend the deepest discussion of the lived experiences of study subjects (Alase, 2017). It is an essential research approach in the field of psychology that stresses offering insights into how an individual understands a situation in a given context. Owing to its participant-orientated nature, the IPA approach enables the study participants to express themselves alongside storytelling their ‘lived experiences’ in the manner that they deem appropriate without any alteration (Alase, 2017). In this dissertation, I focused on analysing the participants' lived experiences regarding mental health and substance consumption, as well as how these two relate to the migration process. Based on the participants’ lived experiences, the following categories emerged: history of drug use, traumatic impacts of immigration detention facilities, experiences of racism and discrimination in detention facilities, inability to access the assistance needed, drug use to cope with the environment, loneliness in Australia, barriers to

building a new life, visa issues and mental health, access to accommodation, access to Medicare, and the status of mental health and wellbeing. I will discuss these categories below.

7.3. History Substance Use

Comprehending historical tendencies in substance consumption offers a fundamental framework for understanding the experiences of Iranian men who have migrated to Australia. Assessing past patterns supports identifying potential elements that might have impacted their behaviours and attitudes towards AOD usage before migration.

Comprehension of Iranian migrant men's attitudes and behaviour towards substance use is vital to inform support and service provision in Australia. It plays an integral role in facilitating them and performing activities for their well-being and health. In Australia, support services rely on the historical and background information of migrants to treat them in an improved manner. The interviews and focus group discussions revealed that many of the participants were substance consumers before migrating to Australia.

"Mine was different. I had been using it when I was in Iran, and I quit when I left. I got clean, and the reason for my immigration was avoiding drugs."

Saeed

"I had been using alcohol before moving to Australia. Then I started to use drugs, pills, Tramadol, and that was increasing over time. I was thinking that the reason for my substance is being in Iran and related difficulties, and I decided to leave Iran and move to Australia."

Saman

The majority of participants reported struggling with drug consumption in Iran. They indicated that they had attempted to stop on numerous occasions but managed to remain clean for

only a few weeks or months at most. The stress, lifestyle challenges, financial constraints, and depression they encountered while living in a developing country compelled them to begin using drugs. Initially, some participants started with alcohol; however, they eventually felt the need for drugs, including the non-prescribed use of psychotropic medication and other substances. The main reason for the substance abuse among some immigrants was the various life challenges they faced during their time in Iran.

"I was working very hard to create a stable life for my family, including my children and siblings, but I constantly felt embarrassed about my inability to provide them with a good life. Financial issues made me so stressed about everybody that I was responsible for them. What steps could I take to ensure their happiness? Nothing; I just used drugs for a little bit to make myself relax so I could work and continue the hard life."

Iman

Due to religious and cultural constraints, drugs are considered culturally unacceptable in Iran. Nevertheless, individuals resort to illegal means to obtain substances in order to cope with the issues that leave them feeling unwell and mentally incapable of confronting those challenges.

"I just wanted to make myself calm; however, my family members and other people were not aware of my substance use, and I did not let them know, as I knew what their opinion about that would be. I used illegal substances because I needed to continue facing my problems."

Iman

As the immigrants faced various life challenges in Australia, many turned to alcohol and other drugs as a coping mechanism.

"I was destroyed and shattered, and I was sleeping in parks and streets; drugs were helping me to tolerate this situation."

Behazad

While living in Iran, the participants were deeply entrenched in substance use due to their experiences of stress and depression, which rendered their lives unbearable. The availability of illigal drugs further exacerbated their addiction. Many of the participants were active members of Narcotics Anonymous (NA) in Iran. However, they did not successfully complete their programme and subsequently relapsed. Nevertheless, they maintain that NA and the 12-step programme are among the most effective methods for abstaining from substances.

"However, NA was very helpful for me to stay clean and take a serious decision to be clean, but I couldn't stay clean for more than a few months as drug was easily accessible in Iran. I don't deny that NA and the 12 steps were helpful, but tension and stress and life difficulties were stronger. I couldn't control myself not to use."

Dariush

While living in their home country of Iran, the participants indicated that excessive consumption of AOD was not a significant part of their lives; some reported using these substances merely for fun. Several individuals mentioned that they could go for several months without taking any drugs, suggesting that they were not addicted to AOD.

However, upon relocating to Australia, some Iranian male immigrants claimed that, due to their willingness and self-control, they had successfully abandoned drugs altogether and were now living AOD-free lives. Unfortunately, this was not the experience of most migrants. Upon their arrival in Australia, the challenges of settling in, assimilating, and finding stable employment compelled many to start consuming AOD.

Although most migrants endeavoured to exercise self-control and remain abstinent from AOD, they found it difficult. Consequently, many succumbed to addiction, resorting to excessive consumption of AOD as a means to cope with the challenges of life in Australia.

7.4. Traumatic Impacts of Immigration Detention

7.4.1. Managing Grief

The interviews revealed that immigration detention is a challenging and arduous phase, during which individuals endure significant emotional and mental stress. Prolonged periods spent in detention facilities in Australia have left Iranian migrants feeling loneliness and isolation, leading to anxiety, depression, emotional trauma, and PTSD. Consequently, many migrants turned to the consumption of AOD both during and after their time in detention as a means of coping with these adverse experiences.

"Initially, during my first days in detention, I experienced profound loneliness, accompanied by haunting memories from the boat and the Indian Ocean. I recall that overwhelming sense of fear, isolation, and severe stress we endured while in the detention centre. All of this ultimately broke my spirit."

Mehdi

Participants expressed that they deeply miss their families. It has been far too long since they last saw their children. When they left Iran for Australia, their children were still quite young, and they voiced concerns about their children growing up without father figures. They are experiencing a significant level of emotional pain and are unable to articulate their feelings. The interviews indicated that most participants experience depression, fear, and anxiety. They are grieving and are anxious about the possibility of never returning to Iran or obtaining permanent visas. Although some participants live with family and friends, they reported feeling lonely. They believe that loneliness can manifest anywhere—whether in Iran, Australia, or any other country—leaving a person feeling empty. To mitigate the overwhelming sense of loneliness, they began to consume substances.

"Regardless, we face challenges as lone-traveller immigrants: we lack family support and often feel isolated. This sense of loneliness, which I have mentioned several times, has had a significant impact on me."

Majid

"I was so lonely; sometimes I wished I could speak English to speak with the officers or other refugees. I missed my family and friends. Sometimes loneliness made me feel like crying; sometimes I thought that nothing would change, and everywhere we were, we were feeling grief, sad, depressed, and annoyed. I was thinking, what is this hard life, and when can I see the happiness?"

Mahmoud

"When I left my country, I hoped to adapt to my new surroundings, find employment, and secure a visa. My children were young when I moved to Australia, and I believed I would soon be able to bring my wife and children here so that we could live happily in a safe environment. However, ten years have passed since my arrival, and I still do not have a visa, leaving me in a state of instability. My children have now grown into young men, and neither they nor I have seen each other during this time. I wonder if I will ever reunite with my family. I feel profoundly lonely, helpless, and hopeless. The only source of joy I have is looking at their photographs and crying."

Shahram

The participants expressed a desire for an organisation or agency to assist them. They recounted how challenges such as unemployment and a lack of housing, which forced them to sleep on the streets, caused them significant suffering. Additionally, as solitary travellers, the Iranian migrants conveyed the distress of being separated from their families and experiencing profound loneliness. Furthermore, their inability to speak and understand English, a language widely spoken in Australia, hindered their efforts to form social connections and build networks, adversely affecting their social lives. I will explore the issues mentioned in greater detail in the subsequent sections of this study. This situation compelled the immigrants to live in isolation from the host communities, intensifying their feelings of loneliness. Many migrants resorted to AOD to cope with the anxiety and stress stemming from their isolation, compounded by the additional challenge of unemployment.

7.4.2. Experiences of Racism and Discrimination

One pervasive problem is the existence of ethnic and racial differences in detention. Excessive representation of individuals of colour, culture, language, and religious people occurs in detention. Within detention facilities, these differences persist in the form of biased treatment. People from marginalised ethnic and racial backgrounds reported experiencing verbal abuse, racial profiling, and biased disciplinary actions. Such maltreatment not only aggravates the psychological and emotional toll of detention but also augments cycles of distrust and suffering.

"I can explain my situation in the detention service. When I arrived, I held all my dreams and hopes for human rights. The researcher's role was to compare the answers and identify the difficulties faced by those wishing to migrate to another country in pursuit of freedom and happiness. In my first year, I was known as WAB709; no one called me by my real name. I did not realise that I would be labelled a refugee; I had no idea that upon arriving here, I would lose my identity and become just a number. I did not understand that I would be referred to as a refugee, and after ten years of living in this country, I am still called a refugee by everyone."

Ehsan

"Once I got into the detention facility, I realised that the saying, all animals are equal, but some animals are more equal than others, is true. Personally, I can't, I'm being called a 'wild animal' based on the fact I arrived here by boat. It was also painful to come to terms with the fact that I was treated differently from other immigrants who arrived by air or who came here as professionals who had already been promised employment. I clearly noticed this discrimination when I arrived here with those individuals.

Mohsen

Interviews and focus groups reveal that participants encountered racism even during their detention. Racism was witnessed among people who travelled by boat and by air. Those who arrived in Australia by aeroplane were provided comfortable rooms to stay in, and they were also allowed to shop from the shops in the immigration detention centres. They shopped for whatever they wanted. However, those who arrived in Australia by boat did not receive the same treatment. They were given too little food and couldn't ask for more. Also, the behaviour and attitude of the camp officers were different from those of the people who travelled by boat and air. The people who travelled by boat faced strict and harsh behaviour from camp officers, while the people who travelled by aeroplane were given respect and dealt with politely. This reflects the mindset of the camp officers and other associated individuals towards the different groups of travellers. The participants who travelled by boat were viewed as inferior compared to those who travelled by air.

'Officer, he said, 'you came by boat." That is precisely what he stated. You are risking your lives and those of your families, suggesting that you believe you can engage in illegal activities in our country as well. When you take such risks, it gives the impression that you can endanger the safety of our citizens. We do not wish for you to be here.

Saeed

"The officer said that you are a burden; you don't deserve the fresh vegetables and fresh food. The refugees that arrived here by plane deserve to have better facilities; if you don't like this situation, you can leave."

Saeed

7.4.3. Unable to Access the Assistance Needed

Detainees frequently face significant obstacles in accessing the assistance they need while in detention, particularly concerning healthcare. Although some may receive necessary medication, comprehensive support for their overall well-being is often lacking. Access to counselling, emotional health services, and legal aid is either restricted or entirely absent. Such neglect renders detainees powerless, as they contend with unresolved mental health issues and legal challenges without adequate support. Additionally, immigration-related concerns can deprive detainees of vital resources and services. This denial of support creates a continuous cycle of suffering, making it increasingly difficult for individuals to address their needs.

"I have requested mental and physical assistance multiple times regarding the challenging issues I am facing but have not received any response. As a result, the issues I am dealing with have continued to worsen over time."

Azad

I was unable to sleep and found myself constantly crying. The physical pain from the boat journey was intense, and the lack of space forced me to sit rigidly for an extended period. While travelling by boat from Indonesia to Australia, I was consumed by the fear of whether I would survive or die, especially as I witnessed many friends dying in front of my eyes. I was in desperate need of a psychologist and required a doctor to examine me, but all I was given was a painkiller, with no specialist available in the detention services.

Farhad

"Many of us got out and did nothing, while others lived a healthy life. While reflecting on your question, I realised that everything we experienced stemmed from fear, loneliness, and factors I failed to recognise at the time. I made a significant mistake by using drugs. I'm here to examine why I perceived things incorrectly during my time in detention services. I also question why I accepted an injection or a pill that the doctor prescribed and how I was deceiving myself into believing in their authority while in detention."

Amir

Detention settings are highly stressful and particularly challenging. Individuals held in such environments may resort to substance use as a means to temporarily escape or alleviate the psychological stress they endure. The distress experienced by migrants in immigration detention facilities can lead to various emotional and psychological effects. For some individuals, drug use may initially offer a sense of emotional relief or control; however, it typically exacerbates mental health issues over time.

"Generally speaking, the feeling of emptiness is deeply rooted within us, beyond the personal illnesses we may face. My use of alcohol has exacerbated my depression, making me feel miserable. Despite having exercised regularly for many years, the excessive consumption of alcohol has led to my developing a fatty liver. We have endured many hardships. I pray to God to save all those who are suffering from alcohol, drugs, gambling, and depression."

Abbas

7.4.4. Substance consumption to cope with the environment

Immigration detention is a challenging phase that impacts the mindset of migrants in a negative way.

"Before I came to Australia, I used to consume marijuana carefully" I mean I didn't need to have it or use it all the time. Even my wife didn't notice. For example, when I was at work just for fun, I was using drugs once a month or for two months, maybe even for three months. I was clean and had enough control to stop using drugs, as I wasn't dependent on them. After moving to Australia, I became addicted."

Iman

It indicated that people were more likely to be addicted to drugs whenever they had negative experiences or traumatic events in their lives. The conducted interviews revealed that some participants resumed drug use upon arriving in Australia because of difficulties faced in immigration detention facilities. Participants who arrived in Australia by boat described poor health care services in detention camps that housed refugees. They experienced a challenging time during detention because of the lack of medical assistance.

"The first thing that new people and new circumstances bring is fear. That's why I kept resorting to the wrong drug. I thought it would alleviate my loneliness, but I soon realised it didn't. Tramadol does. If Tramadol didn't, something else would. I encountered the wrong people, you know, because I arrived unaware and lonely. The most significant issues I faced were discrimination and a sense of deadlock. They stressed that I would remain in this detention indefinitely. I would never experience the true essence of Australian culture."

Amir

The rules of detention were so strict that clients were not permitted to visit hospitals for the necessary consultations and treatments regarding the factors that had led them to consume alcohol and AOD. Along with the unfavourable conditions, the lengthy wait at detention facilities for processing and visa issuance compelled immigrants to resort to AOD as a coping mechanism, temporarily numbing the pain and psychological challenges they faced. Even after obtaining a visa and being released from detention, these immigrants continued to use drugs, having become habituated to them.

"A long-term detention centre could lead to drug use, even for someone who has never used any drugs, including cigarettes."

Damoon

7.5. Loneliness in Australia

The discussion and interviews with the participants revealed that the concept of substance use served as a coping strategy in detention settings, often emerging as individuals face various emotional challenges, such as grief from family separation and social isolation due to language barriers and cultural dissonance. These components jointly play an essential role in the vulnerability of detainees and emphasise the necessity for inclusive support and intervention.

"I've been hard hit by feelings such as loneliness. It still hurts me. It feels like a rootless branch moved anywhere in the blowing wind. In the past those thoughts were afflicting and made me feel empty, so I had been ruining everything in a blink. Still now this feeling grabs me, but I've accepted it. After a long time, slipping many times, with my perception and my age, I've calmed

down a little bit, but I still have pain about this feeling of loneliness. Nothing bothers me but that."

Abbas

Participants reported experiencing profound grief and emotional distress due to their separation from loved ones. This separation, often marked by uncertainty and lasting duration, engenders feelings of anxiety, loss, and sadness. In their attempts to cope with this overwhelming grief, some participants mentioned resorting to drugs as a means of alleviating their emotional pain while grappling with the quest for solace.

"Loneliness, sadness, far from our family and friends – what could we do? Nothing seemed helpful; it was painful. We tried various activities to distract ourselves, but nothing worked. I remember we went fishing for 3–4 hours. I love fishing; it was calming, but gradually we turned to alcohol. It started with one beer, then two, three, and eventually five [laughs]. We came to realise that we had no jobs and that our lives were ruined. We spent our time on the phone, drinking beer. At one point, I realised I had consumed 24 beers."

Pasha

Many individuals moved to Australia alone, leaving their families and friends behind. Furthermore, they struggled to understand the language spoken in Australia, which made communication with others exceedingly difficult. The feelings of loneliness, the inability to communicate, the fear of unfamiliar people and places, and the experience of being detained contributed to their extreme discouragement and lack of motivation. Ultimately, they turned to drugs as their only source of comfort and relief from their emotional and psychological struggles.

“When we arrived at the detention service, the support workers provided us with a list of services to contact for vouchers. They did not advise us to learn a language or acquire skills to gain employment and earn money. My daily routine involved calling that list from morning until afternoon, requesting vouchers and food, as I remained at home and unable to work due to not having a work permit. If I had been allowed to attend TAFE, I believe I would have become a successful businessman and would not have found myself involved with drugs. I did not create this difficulty for myself.”

Behrad

"That void of loneliness pushed me into a relationship with a woman 16 years older than me. I got in that relationship then I realised I'd been involved in some issues … you know … I noticed I couldn't detach. I knew that my behaviour was wrong, but I felt powerless to change it, and I continued to consume more and more substances. Besides alcohol, I was using anything I could get. I was overusing it to kill my pain."

Saman

The participants detailed how various factors, such as language difficulties and social isolation, contributed to their experiences of loneliness while residing in a foreign country. Language barriers remained a significant concern even after they departed from the detention facility, which further exacerbated social isolation and fostered feelings of helplessness and alienation. Participants who struggle to communicate effectively with others often find themselves

cut off from social support systems. This ensuing isolation and loneliness compel individuals to seek relief through substance use, offering a reprieve from the emotional toll of their isolation.

"It was the fear of the future. It was disappointing. We encountered the wrong people. Our lack of language skills tied us to a community that was not as strong as we were. Furthermore, other Iranian refugees informed me that I couldn't establish connections with foreigners at all because my English was inadequate, and there were no language classes available."

Amir

Research reveals that cultural dissonance is another critical element that exacerbates vulnerability in detention. Detainees from distinct cultural backgrounds consider it challenging to adjust to the values, norms, and expectations within the detention setting. This dissonance results in feelings of frustration, confusion, and disconnection. Some individuals depend on substance consumption to overcome the stress related to steering unknown cultural territory.

"I attempted to connect with colleagues from diverse backgrounds at my construction job, but after several attempts to communicate, they rejected my efforts due to our cultural differences. I may have engaged in behaviour that was disrespectful towards them. For instance, I thought that giving gifts and treating their children kindly would make their parents happy; such conduct is considered normal in my culture. However, they seemed uncomfortable with anyone interacting with their children."

Ahmad

7.6. Barriers to Building New Life

7.6.1. Barriers to Accessing Employment

Employment issues are a significant cause of mental illness and substance use among Iranian forced migrant men, many of whom lack identification documents due to unclear residency status. This problem primarily arises from a lack of understanding of Australian laws. Since all the country's laws are written in English, their limited education hinders their ability to comprehend migration laws, improve their residency status, consult lawyers and other professionals to resolve visa issues, and obtain the identity cards and work permits necessary for securing employment and earning a living.

"I'm experiencing mental pain. I continue to face obstacles in my relationships and my job. I live in fear that if something happens to my parents and I don't have a visa, I won't have money or employment. I'm suffering. What if I struggle to form meaningful relationships? Building a relationship requires financial stability; I need to work to earn money. What if I pass away and find myself buried here, alone, homeless, and with nothing? This fear haunts me."

Mehrdad

Many participants struggled with English, which hindered their ability to communicate with local residents, apply for jobs, check their visa status, and establish a social life. They felt disheartened due to the lack of accessible resources for learning English. Additionally, the participants encountered a significant lack of support from the host community in Australia. For example, they perceived that local communities were unwilling to offer assistance, particularly in

the form of employment opportunities. This made it challenging for them to secure jobs and earn a living to support their families back in their countries of origin. Consequently, this situation led to serious mental distress, prompting some participants to resort to substance use as a means of coping.

"We felt alienated; we felt we were different, and we couldn't solve our problems because our English was not our first language. The good jobs are for the original people; the even handier jobs with better salaries and money are for the people who are originally from Australia. I need to send money to my family in Iran. I live with all the difficulties, but my family is waiting for me to transfer money to them. It was crucial, and it even impacted our drug use."

Pasha

Due to their fear of detection by the police, participants expressed a lack of motivation, leading them to prefer hiding over applying for visas. Furthermore, they lived in constant fear of being apprehended by immigration authorities at any moment. Additionally, the majority of participants reported that they journeyed to Australia by boat. Consequently, the fear they experienced at sea and the length of the journey had a significant impact on their mental health. These experiences led them to feel that they had no option but to resort to the consumption of AOD in an attempt to find relief from their distressing experiences and emotional pain. For many, it was impossible to forget their journey to Australia and the hardships they endured. Instead, a number of them contemplated applying to renew their visas, hoping to secure an opportunity to work in the country and earn a decent wage that would enable them to lead a better life.

"Since I got to Australia, my consumption has increased day by day, and I can say it was always because being in a foreign country and being unemployed is bothering me too much. I took shelter from the condition, without a job and with excessive pressures, that they had made for us by getting into drugs. I was trying to take those pressures off my back. Now I don't know if it was right or wrong. Of course, I understand it was wrong, but back then I felt like I didn't have any choice except drugs. So, I used to take any kind of drug which I had access to. I sought to get high as a way to alleviate the pressure I was feeling."

Shahed

The COVID-19 pandemic compounded participants' difficulties in finding employment. These people migrated to Australia with the hope that they would get better opportunities to earn, meet their basic expenses, and provide a reasonable living standard for their families. However, the pandemic of COVID-19, along with the visa issues, made the participants feel unimportant due to difficulties in finding meaningful jobs that could help them earn a living. They faced immense pressure to cover expenses such as rent, food, transportation, and their children's education but remained unpaid for several years, which prevented them from fulfilling their responsibilities. The stress and depression they experienced led them to use illicit substances.

"I arrived here during the COVID-19 pandemic, and things were challenging as finding employment proved to be difficult. Most potential employers had closed their businesses, making it hard to secure a job. My situation felt unbearable; I struggled to find food and pay rent after exhausting the money I had brought with me when I migrated from my home country. My family back home relied on me for support, and I desperately wished for someone to help me. I endured

a great deal, leading me to turn to alcohol and marijuana in an attempt to cope with the stress I was experiencing."

Majid

7.6.2. Visa Issues and Mental Health

Participants reported experiencing anxiety due to visa issues. They were concerned about the potential consequences if a family member back home were to pass away while they lacked a visa; they wondered if they would be buried in Australia. These fears adversely affected their relationships and connections with family members in their country of origin, resulting in emotional distress and mental anguish. Participants expressed concerns that their physical separation from family could negatively impact their relationships, resulting in restless nights.

Another element contributing to mental health challenges and the use of AOD among Iranian men was the uncertainty surrounding their visa status. Many of the migrants interviewed expressed discomfort with living in a state of uncertainty and waiting for extended periods without knowing whether they would receive a visa. Numerous individuals linked the insecurity and unpredictability of their visa situation to an increase in the severity of their mental health difficulties. Many wished for a prompt response regarding their application, even if it meant being denied the visa, as they sought to alleviate the uncertainty in their lives.

The ongoing preoccupation with the potential outcomes of their visa applications, which they regarded as a crucial determinant of their future, had a detrimental effect on their mental health, contributing to feelings of depression and anxiety. Furthermore, it was a significant factor in their substance misuse.

"Insecurity is a significant source of distress for me; it's challenging! I would rather know that I won't obtain the visa for the next hundred years than endure the uncertainty of waiting for a migration response and grappling with the possibility that my visa might be accepted or not. This internal dialogue is truly painful…"

Majid

The participants expressed dissatisfaction with the outcomes of visa processing. Many of their visas were valid for only a short period, which did not reflect the length of time they had waited to obtain them. The experiences they endured, particularly concerning the delays in receiving their visas and the limited validity, led many participants to experience anxiety and depression. As they noted in their conversations, these mental health issues resulted in some participants misusing substances.

"If anyone were in my position after living for ten years in Australia, only to find himself with a three-month visa, could he truly be happy? Or if he were in my situation, having relapsed into drug use five or six times and reached the brink of death before being revived, would he be able to find happiness?"

Hamed

Even for those participants who had their visas already processed and were living in Australia legally, they did not feel comfortable when they came into contact with Australian police. This further inflicted anxiety and depression on the participants, thereby exacerbating their mental health and AOD consumption challenges.

"Police behaviour affects us more significantly, particularly those with visa issues. It also impacts me, even though I hold a visa with no particular problems and am living here legally. I feel afraid when I encounter the police as well. As individuals struggling with addiction, we face difficulties and therefore require special support, don't we?"

Hassan

Through focus group discussions, it was found that participants remained afraid of the treatment and behaviour of the people they faced because of visa issues and the absence of work permits. Some participants received a visa valid for six months, but they did not obtain a work permit. They were provided with a basic salary, which was just enough to meet the basic expenses.

"I slept in the streets, feeling lonely and friendless. No one offered assistance, but the lack of help only compounded my sense of overwhelm. There was nothing I could do, and I felt lost; I lacked the necessary experience. Years later, I became shaky; I experienced twitches and felt increasingly anxious about my concerns regarding obtaining a visa. This visa remains crucial for me to this day. I plan to apply for a visa because if I don't, there is a risk that the immigration police might apprehend me."

Iman

"Visa issues are one of these roots. The visa issue has many invisible impacts. For instance, the constant problem may be caused by the immigration system and feelings of solitude. These things affect me a lot. I mean, we can't analyse them carefully, and there is no one to bring it up to show why I was afraid of the police in Iran or now. I'm not carrying any drugs; I did nothing wrong, so why am I scared of a police car in the opposite lane?"

Javad

7.6.3. Access to Accommodation

The participants experienced challenges in getting a home/house to live in. Even for those who had the money to rent an apartment, it was not easy getting one. Some participants stated that they spent about three months walking around their respective localities to look for housing. In some cases, the real estate agents were asking for hefty bribes which the participants could not pay. They termed the experience discouraging and heartbreaking since most of them had shifted to Australia in search of a better lifestyle and freedom, but the reality was different since they faced giant hurdles in getting access to the basic necessities of life, such as housing. Inability to acquire housing forced participants to spend some nights in the streets. Such experiences caused mental health challenges among participants, with some resolving to consume AOD.

"The year 2012, sorry, guys, I speak because I think we are all like each other, no differences. Despite the ups and downs, we remain the same. In 2013 they gave us a 6-month visa. We didn't have a work permit. They paid us a salary that was sufficient for living expenses, so we spent almost 3 months searching for a house, relying solely on walking. We couldn't even afford mineral water. They didn't let us rent a house because we didn't have an ID card or driving licence or rental history."

Hossein

"I was living with 6 or 8 people in a shared house, as I was unable to find accommodation. I did not have a visa, work, or enough money. My housemates were using drugs and faced the same challenges and conflicts that I experienced while moving to Australia. They were all challenged with the same issues, mental health, and they were all using different drugs or meds or alcohol to

escape from their difficulties or escape from the feeling of loneliness, shame and embarrassment for not having safe accommodation. I had relapses with drugs, and every day my usage was increasing."

Shahed

7.6.4. Access to Medicare

The participants reported experiencing a lack of access to appropriate medical treatment in Australia. Those who arrived on boats shared that they brought various health problems and issues stemming from the trauma and life conditions encountered during their journeys. Their difficulties in accessing timely healthcare services in Australia were exacerbated by delays in visa issuance upon arrival. This situation heightened the risk of their health conditions deteriorating, particularly for individuals with pre-existing health issues or mental health challenges resulting from their experiences. Participants noted the challenges they faced in obtaining regular check-ups, screenings, and vaccinations. Consequently, avoidable health conditions often went unnoticed and untreated, leading to more severe health problems over time. Access to both curative and preventative healthcare services is essential for maintaining overall health and preventing potential escalation of health issues. Participants expressed a willingness to engage with psychological services in Australia.

"I sustained various physical injuries, such as the flu and an injury to my hand from work. However, since my employment was illegal due to lacking a visa and work permit, I did not have access to Medicare and could not visit a doctor. I found myself with no other option and resorted to using illegal medication as a painkiller. Believe me, if I had received an education, I would not have resorted to using illegal pills."

Saeed

Some participants sought counselling services because the traumatising stories shared during their time in detention facilities lingered in their minds and frequently occupied their thoughts. However, they were unable to receive assistance from psychologists due to language barriers, difficulty in fully expressing their feelings, and the psychologists' lack of experience in working with immigrants. The participants viewed their encounters with psychiatrists as a significant demotivating factor, as they had been hopeful of receiving support from the psychologists.

"I visited a psychologist when I got out of detention, but it was not for immigration itself—migrating to Australia. It was because of 3 or 4 of my friends. One of them was Abu, also known as Abu Jafar; he took his life. Saeed and I brought his body down. It's still in my mind. I will never forget it. David, an Englishman, took us to another level. He also hanged himself. I and Mohammad brought him down. There was another guy. I don't remember his name. These things were in my mind. I repeatedly sought help from a psychologist, but I had to cover the costs myself because I lacked Medicare coverage."

Saman

"I have had a counsellor in Iran, and whenever I was feeling triggered, I could see her. However, there were times when I could not see her, as the cost of the visit was often prohibitive for me. Nevertheless, I understood that when I felt mentally stressed and anxious, it was important to consult a psychologist, counsellor, or similar professional. In Australia, accessing this support was not feasible for me, as I needed to see a GP first to be referred to a counsellor. Unfortunately, I did not have Medicare."

The limited or complete lack of access to health care services profoundly affected the mental health of the participants. They recounted how their journey from Iran to Australia imposed significant mental health challenges that necessitated assistance and counselling. The inability to access these services forced the participants to live with their conditions, with many struggling to manage their anxiety and depression independently, which heightened the risk of their mental health deteriorating.

7.7. Status of Mental Health and Wellbeing

7.7.1. Health Literacy and Help-seeking

Forced migrants often come from diverse cultural backgrounds and possess limited proficiency in speaking and conversing in English, which is widely used in Australia. This issue relates to language barriers that hinder their ability to communicate with mental health and counselling specialists in the country. Even when participants reach counselling centres, they struggle to understand information pertaining to mental health. Additionally, the participants reported facing ongoing stigma while attempting to access mental health and counselling services in Australia.

"I did not know anything about mental health; I thought I was just tired, overwhelmed, or having sleep issues. I did not realise these were related to my mental health. Even if I had known, how could I explain it in English? If I caught the flu, I still wouldn't be able to describe the symptoms in English; just thinking about it makes me feel unwell."

Hamed

They explained that their culture does not view mental health problems as a disease but rather as a sign of weakness, particularly for men, who are expected to remain strong. This stigma prevented the participants from seeking help and support from relevant agencies and organisations. They recounted how the stigma led them to endure traumatic experiences, such as feeling sidelined, ignored, and unimportant while in a foreign country. These experiences resulted in a heightened prevalence of mental health issues, including anxiety and depression, among the participants and exacerbated existing mental health conditions for those already struggling.

"As you might be aware, our culture back at home does not acknowledge mental health issues as a treatable disease but a sign that one is not man enough. Given this belief, would you genuinely want to associate with an organisation that provides mental health services? Where will you start? By doing this, you keep everything to yourself and avoid feeling ashamed for not meeting traditional standards of masculinity. You experience feelings of loneliness and fatigue. I used to use drugs to get high. I was always consumed in such a way that, for example, I was not in this world at all. I wanted my mind to be free, not noticing how time passes, when the night ends and when the day passes. That was what it was all about."

Shahed

"Once I raised my anxiety and depressed mood with one of my friends, and he said, 'It's better you don't say anything about that to other people. They think you're insane, and no one will marry you. You won't be able to find a job; just try to use over-the-counter medication or some drugs. You'll be fine.' That's why I did not seek any help and just tried to keep my emotions to myself."

Amir

7.7.2. Psychiatric Diagnosis

Psychiatric diagnosis posed challenges due to cultural differences, language barriers, the difficulty in expressing stress, and the lack of mental health professionals familiar with the cultural nuances of this migrant population.

"My roommate introduced me to a psychiatrist after noticing my mental health issues. I struggled a lot to share with the psychiatrist, especially when asked to narrate what I was going through. Some of the psychiatrist's words were incomprehensible to me due to my unfamiliarity with his English. I kept on saying pardon, until the psychiatrist seemed tired of me."

Hossein

7.7.3. Ongoing Traumatic Impacts of Detention

Traumatic experiences can lead to memory loss or vivid flashbacks. These symptoms are indicative of various conditions, making it essential to provide access to support and necessary medical assistance. For many individuals, recovering from painful memories of loneliness, fear, and the challenges encountered during detention is difficult. The system's failure to provide these individuals with the necessary opportunities to heal from their trauma closely links this issue.

"Mental and moral problems resulting from immigration", you know… Aside from disease, we face an issue known as addiction, which brings us significant challenges. Immigration has introduced various psychological difficulties; we cannot forget our experiences in Indonesia, during the occupation, or while dealing with the denationalisation service, waiting

for visas and addressing work accommodation issues. Each of these experiences represents a distinct traumatic event from our childhood in Iran. I don't believe we can forget any of this; it's very difficult, and I think all the participants in this group understand what I am saying."

Hossein

The participants find it difficult to escape the memories that continue to haunt them. They explained that even after obtaining a visa and being released from detention facilities, they remain in a state of constant fear, which prevents them from leading a normal life.

In addition to their personal struggles and concerns, the participants reported that sharing their experiences with one another during their time in detention had a negative impact on them. While residing in these facilities, they formed friendships and confided in each other about their problems, despite the adverse conditions. Some participants mentioned that certain friends developed suicidal thoughts and even attempted to take their own lives while in detention. As emotional bonds were formed with their peers in these facilities, the shared narratives took an emotional toll on the participants, making them more susceptible to anxiety and depression, as they feared they might endure similar experiences.

"Everyone in detention services shared similar problems; we had no good news or happiness to share, and during our free time, we simply sat together discussing our difficulties, concerns, and negative emotions. Friends who were in detention before us were more withdrawn and depressed; they shared their issues and suicidal thoughts with us, and we were crying and thinking a few months later we would be in their situation, and it was so scary."

Azad

At this stage, they began to accept reality and recognised that the trauma experienced in immigrant detention facilities adversely affected their future lives, making it difficult for some individuals to integrate into society. For instance, several participants shared that they felt persistently demotivated and disheartened, struggling to find meaning in their lives in the new country. Additionally, they found themselves unable to heal from the emotional trauma endured throughout their journey from Iran to Australia and during their time in detention facilities.

"Even after leaving the detention facility, I found myself haunted by endless memories of the fears I faced while there. The harsh and lengthy journey from Iran to this place only added to my distress. I struggled to find meaning in life, as I was unable to lead a normal existence. In fact, I resorted to alcohol to help me sleep, but the same problems persisted the following day."

Ali

7.8. Chapter Summary

In this chapter, I have provided the results of the focus group interviews. The description of the results is accompanied by participants' descriptions and narrations of their experiences with mental health issues and consuming AOD as well as seeking help from mental health services in Australia. I used pseudonyms instead of participants' real names. Various themes emerged from the data collected during focus group interviews with the participants. These include the history of drug use. Some participants reported that they began consuming AOD while still in their home country of Iran, as a response to the mental health issues caused by poverty and political instability there. In addition to the migration journey itself, the participants described how being detained in detention facilities characterised by unfavourable conditions for long periods caused mental health

issues such as anxiety, depression, PTSD, and emotional trauma. Some of them resolved to consume AOD to get relief from the bad experiences.

The participants recounted instances of racism and discrimination during their incarceration in detention facilities. Those who arrived by boat faced unfair treatment compared to those who arrived by air. They were unable to access the essential help and assistance they desperately needed, such as healthcare, counselling, and legal services, which were limited or entirely absent in detention facilities. To cope with the unfavourable conditions, the participants resorted to alcohol and marijuana. Moreover, the interviews revealed that participants had experienced loneliness since moving to Australia alone, having left their families in their home country, Iran. While in Australia, the participants struggled to connect with the host community due to a communication barrier, which further exacerbated their emotional and psychological suffering. Most participants found it challenging to secure employment and lacked adequate support to help them start a new life and integrate into society. Other challenges contributing to their mental health issues included difficulties in obtaining visas, accommodation, and medical care services after leaving detention facilities. Additionally, due to their struggles with English, some participants faced obstacles in seeking help. Stigma associated with mental health issues and substance use hindered some forced Iranian migrant men from seeking assistance from relevant agencies and organisations. Even for those who managed to access psychologists or psychiatrists, obtaining a diagnosis remained problematic due to cultural incongruence and the language barrier between the participants and mental health professionals.

This often resulted in misdiagnoses or inadequate treatment plans that failed to address the unique experiences and needs of the participants. Consequently, many continued to struggle with

their mental health, feeling isolated and unsupported in their journey towards recovery from substance use.

The voices and lived experiences of the participants presented in this chapter underscore the profound psychological and social challenges faced by Iranian forced migrant men in Australia, particularly concerning substance use, mental health, and access to care. While their stories provide critical insights into shared struggles, the next chapter will shift focus to my personal experiences working with Iranian men who face mental health and AOD issues, alongside their experiences with me; I will compare these two perspectives. This comparison will illuminate the complexities of their situations and emphasise the importance of culturally sensitive approaches to addressing their needs. By integrating both the participants' narratives and my experiences, I aim to foster a more profound understanding of the multifaceted barriers they encounter in seeking support and recovery.

By adopting an autoethnographic lens, I reflect on my life as a counsellor who shares a similar culture and language with those I am studying, utilising my personal narrative to enhance my understanding of the issues explored in the interviews and focus groups. This self-reflective exploration provides a complementary, first-person perspective that situates my experiences within the broader cultural and structural context outlined in this chapter.

8. Autoethnography Findings

8.1. Introduction

The autoethnographic research provides an examination of my personal experiences as a female bilingual counsellor specialising in AOD treatment at an agency, where they were involved in enabling AOD and mental health services. The tale not only engenders an immersive experience for the readers but also presents a culturally pertinent and topical viewpoint on the subject of substance use. As stated earlier in chapter six, I also integrated participants' perspectives and opinions to support my autoethnographic findings. Initially, I experienced a sense of apprehension, but eventually, I mustered the courage to introspect and pose these queries to myself: What is the underlying reason for my reluctance to compose this particular section of my dissertation? Is my fear rooted in my identity as an Iranian female who internalises social expectations and is apprehensive about being evaluated based on those standards? Is my fear due to worries about my safety or that of my friends and family? As a female, my recollection entails the perpetual need to safeguard myself against various forms of abuse, including physical, verbal, and financial maltreatment, with a particular emphasis on preventing instances of sexual harassment. Currently, I am conducting research on a cohort of Iranian forced migrant men who hold the belief that the female gender is inherently feeble. To assert dominance, these individuals employ the term "Zaifeh" as a pejorative reference to women. My writing aims to provide personal experiences and insights to Iranian women working alongside Iranian men. The aim is to comfort them, help them understand the challenges they may face in their professional journey in Australia, and highlight the possibility of success. The following topics and smaller ideas came up from in-depth talks with participants who had already been interviewed individually, as well as from my own observations

and the results of a FGD with some of these participants. We discuss the themes and subthemes in detail in the following paragraphs.

8.2. Trust

During the first therapeutic session, I explain the concept of confidentiality. I recall a time when I began evaluating Iranian forced migrant men who consistently exhibited a tendency towards reticence and reluctance to engage in conversation. They were expressing nonverbal disapproval by shaking their heads. The occurrence persists during my sessions with new clientele.

The clients had reservations about placing their trust in me. They were uncertain about my ability to maintain confidentiality and safeguard their privacy. One client's spouse had reported him to the authorities, which caused him serious concerns about establishing trust; he asked me to explain the measures I take to ensure trust and confidentiality so that he would feel comfortable sharing his personal issues with me. Based on my gender, one female client refused to share his story, as he had trust issues. He claimed that my level of proficiency and my expertise were insufficient to provide him with assistance. It is my usual practice that I attend to approximately five male clients of Iranian descent daily. By the end of each day, I experience feelings of frustration and exhaustion due to the usage of certain vexatious phrases by these clients. The statement "I cannot trust a woman" elicits feelings of disappointment and shame within me. As an experienced counsellor, I am currently experiencing disappointment due to my inability to establish trust with Iranian men. The persistence of dysfunctional beliefs among Iranian men in a developed country such as Australia in the 21st century elicits feelings of shame. From what source does this sexism originate, and what is the nature of these sentences? Throughout the course of Iranian history, women have been known to diligently engage in laborious activities in order to

provide for their husbands and families. The individuals in question exhibited a high degree of obedience towards their male family members, including fathers, brothers, and sons.

Within the broader societal context, women were compelled to comply with all men outside of their immediate families, including but not limited to their co-workers, superiors, chauffeurs, and neighbours. When many Iranian clients try to exert control during sessions by using disdainful expressions, threats, raised voices, or profanity, I feel revulsion towards the condition of their gender and how historical factors influence the behaviour of this current demographic.

"As a woman counsellor I don't trust you. I'm not sure that you can keep my secrets and privacy."

Mohammad

"My wife reported me to the police. So, tell me how I can trust you to share my problems with you?"

Saeed

"I won't talk with you. I don't trust you because you are a woman. You are not good and skilful enough to help me. I'm here just because my parole officer referred me for counselling."

Vahid

8.3. Comparing

The clients were comparing their situation with mine in relation to gender differences. They asserted that they all have similar levels of education; however, my employment in Australia is supported by government assistance.

"I'm educated like you, but you are employed in Australia because this government supports you. This country just supports women. When you think of who you are, remember if you were in Iran, you must respect and stand before me, as I am a man."

Ali

This nation exclusively provides support for women. When considering one's identity, it is important to note that in Iran, societal norms dictate that individuals must demonstrate respect and deference towards men. In the present circumstance, I experience the emotions of apprehension, insufficiency, or a sense of unworthiness about receiving esteem. It is my perception that they intentionally aim to elicit negative emotions from me, possibly with the intention of highlighting her vulnerability and fragility.

I really want to convey that I have dedicated a significant portion of my life to acquiring and utilising the English language at various academic institutions. I wish to convey that I have encountered numerous challenges and arduous circumstances in my pursuit of English language proficiency. One of the primary motivations for my migration to Australia was to secure the recognition of my inherent dignity and entitlements as a human being without being subject to gender-based discrimination or subordination.

8.4. Controlling and Rude Behaviour

The clients displayed controlling and rude behaviour towards me, marked by a variety of negative emotions such as anger, nervousness, and irritation. In both individual and group sessions, they attempted to dictate the manner in which I should assist them, showcasing a dominating and controlling attitude. Since the majority of the clients I worked with were referred by community corrections, the police, or the court, they sought to impose their demands on me about how to achieve a positive outcome. The few conversations highlighted exemplify the behaviour I encountered while working with Iranian forced migrant men as clients.

"Just listen to me, and when you meet my wife in counselling sessions, obey whatever I tell you."

Farhad

"Did you understand what you should report to my parole officer?"

Vali

"Text me the date and time of my session, and if I do not attend, report it to my parole officer that I have attended."

Navid

8.5. Threatening Behaviour

The clients also used threatening tones and words towards me, which resonated persistently within my auditory perception. I experienced a range of negative emotions, including stress, worry, fear, and a sense of insecurity. For a considerable period, Iranian women have habitually maintained silence in various instances of physical, sexual, verbal, and psychological maltreatment due to their gender, which precluded them from expressing grievances.

"Before reporting to my parole officer, think about your husband and your family."

Ashkan

"Remember I know where your husband is working. Shut your mouth and remember I'm a man."

Kourosh

8.6. Breaching Boundaries

During the initial sessions, I consistently gave clients an explanation of the code of conduct, the policies of the organisation, and my professional boundaries. However, it has been observed that certain clients repeatedly disregard these guidelines and boundaries in their conduct. There have been instances where certain clients have made repeated attempts to contact me via telephone while I was engaged in a session with other clients. Additionally, some clients have attempted to reach me outside of regular work hours, including weekends. In instances where I was unable to answer incoming calls, the callers resorted to leaving vociferous messages on the voicemail system, often containing disparaging remarks regarding my work in a professional capacity.

I experienced a range of negative emotions, including anger, embarrassment, fatigue, and distress. Experiencing emotional distress due to perceived verbal mistreatment and unfounded allegations brought stress and depression to me. A significant number of Iranian women have reported experiencing a sense of inadequacy resulting from self-comparison with men. Experiencing emotional distress is a common reaction when subjected to criticism that employs vulgar language. Nonetheless, it is important to acknowledge that such behaviour constitutes a violation of personal boundaries, and one may not necessarily be at fault in such situations.

8.7. Flirting

The clients also showed a flirting attitude towards me. As a female, I experienced a range of negative emotions, including discomfort, disgust, hurt, sadness, and occasional feelings of terror due to the clients' attempts to pass flirtatious remarks towards me.

A significant proportion of Iranian women have experienced instances of sexual assault or unwarranted sexual behaviour in various settings, such as their families, schools, public spaces, and workplaces. I was compelled to recall instances of physical or sexual conduct and aggression that I have encountered.

"What a beautiful counsellor! If I had known my counsellor was a woman, I would not have refused to come for a counselling session."

Azad

"If you go on a diet and make yourself slim fit, I will like you more."

Amir

"Are you married? Why did I not see you before you got married?"

Javad

8.8. Working with Aggressive Clients

During my tenure as a bilingual counsellor at DAMEC, I encountered numerous challenges related to clients displaying aggressive behaviours towards myself and other clients in both group and individual sessions. In this section, I will outline some examples of direct and indirect behaviours that made me uncomfortable as a counsellor while engaging with clients.

For example, the organisation provided mobile devices to all counsellors, which allowed clients to initiate direct communication, schedule appointments, and address additional concerns. A significant number of clients used the work phone to send personal concerns and inappropriate images.

Working with individuals affected by AOD issues and mental health challenges requires interaction with those who may exhibit passive or aggressive behaviour, some of whom have criminal histories. On several occasions, clients sent derogatory messages to my mobile device. When interpersonal conflicts arose between clients associated with the organisation, some attempted to coerce others into leaving or to block their admission.

Throughout both individual and group sessions, I was compelled to educate clients on the inappropriateness of such behaviours towards others. Despite my efforts, there were numerous instances where they issued severe threats against fellow clients and myself.

During these interactions, individuals often used coarse language and displayed menacing nonverbal cues, both in group settings and one-on-one therapeutic environments. They also delved into the personal lives of others.

I repeatedly informed them that recording the sessions was against the code of conduct. Nevertheless, they made several attempts to record my voice, threatening to misuse the recordings and the content of the sessions.

Their interruptions significantly disrupted both group and individual sessions. Group members exhibited a lack of conversational turn-taking, frequently interrupting others and creating a hostile atmosphere. Additionally, they consistently arrived late to both individual and group therapy sessions.

Clients often attended both individual and group therapy accompanied by aggressive individuals, fostering a gang-like environment. They brought in people who were not affiliated with the organisation without prior notice, which was explicitly against organisational policies. When I raised this concern, they expressed indifference and insisted they would act as they pleased.

The individuals mentioned displayed a strong reluctance to change their behaviour, demonstrating unwarranted confidence in their knowledge and abilities.

8.9. Immigration as the Illness

The challenges faced by Iranian forced immigrant men have led to numerous referrals and requests for counselling sessions from those who have recently migrated. Notably, some clients approached me with an awareness of their mental health struggles, as well as specific issues related to mental health and AOD. This self-awareness is the reason they sought counselling. Participants in the focus group indicated that the difficulties associated with migration adversely affected their mental health, resulting in substance use, which they described as an illness in their lives.

One participant mentioned during their interview that they faced challenges such as language barriers, family dynamics, feelings of isolation, and difficulties in forming friendships, all of which impeded their ability to build relationships. They conveyed feelings of being strangers and experiencing confusing emotions. The deep sense of loneliness often drove them into relationships with older women, further contributing to their confusion. All the challenges stemming from their loneliness and migration led to mental health and AOD issues to the extent that they referred to migration itself as an illness.

"The other participants here were discussing their language barriers, family issues, feelings of loneliness. I felt like a stranger as well, you know? I was experiencing some unsettling emotions.

During that time, I found myself in a situation where I was vulnerable to various forms of abuse; in other words, I could have been easily exploited. If someone had asked me to traffic drugs in exchange for money or substances, I would have considered it. That overwhelming sense of loneliness led me into a relationship with a woman who was 16 years older than me. I became involved, only to realise I was entangled in troubling issues. I noticed I couldn't detach myself from the situation. I knew it was wrong, but I felt powerless to change it, and my consumption of substances increased. Aside from alcohol, I was using anything I could find. I abused substances to numb my pain. I couldn't escape that unhealthy relationship. In summary, all of this stemmed from the challenges of migration that ultimately made me unwell."

Saman

Participants discussed their problematic relationships and soon realised they were facing various issues, including their inability to detach. They recognised that their situation was troubling but felt powerless to effect change, which led to increased consumption. In addition to alcohol, they resorted to using anything they could obtain, misusing drugs that could potentially be fatal. They believe that immigration has contributed to the development of an illness.

"There were mental health issues which pushed me to consume alcohol Everything I experience as migration challenges has left me feeling tired and exhausted. I turned to drugs to escape reality, consuming them in a way that detached me from the world around me. I sought to free my mind from all negative thoughts, oblivious to the passage of time—when night ended, and day began. This was my existence; I suddenly found myself a drug user, mentally and physically unwell, and excessive alcohol consumption rendered my liver ineffective."

Shahed

8.10. Facilitators to Accessing Support

Forced migrant men from Iran consider that consulting a mental health specialist or counsellor is the most effective way for individuals dealing with mental health and AOD issues to achieve sobriety. It is crucial for these individuals to seek assistance with challenges such as substances dependency, mental health issues, visa issues, and other factors that contribute to their health challenges.

Furthermore, it is important to note that there is no definitive protocol or intervention that can be universally applied to Iranian forced migrant men suffering from mental health disorders and substance abuse issues. As counsellors, we employ a variety of strategies and treatments and then analyse their effectiveness. This necessity arises from the presence of pre-existing mental health conditions among some individuals prior to their relocation to Australia, as well as the detrimental impacts of detention, visa-related stress, familial difficulties, feelings of isolation, anxieties about the future, and other associated factors. Consequently, research that addresses the needs, desires, and concerns of participants would be beneficial for counsellors to determine which therapeutic approaches or support mechanisms might be effective for this population in relation to their mental health and substance use. Therefore, I have included some of the ideas and beliefs expressed by participants during the focus group interview.

"I was going mad because of the repayment debt, but when this woman was introduced, it was resolved, and I felt a sense of relief. A few years later, I found myself in a dire situation: no money, Covid, no Sertraline, and suffering from back pain. She wrote five letters and recommended me to various organisations. She did so much, but unfortunately, they didn't

respond, and then she even referred me to rehab. Her actions were truly impressive! The greatest help came from a doctor she introduced me to. My life became more balanced thanks to the medication. I am truly grateful and feel indebted."

Abbas

"The help which the counsellor gave to me meant that I was introduced to a psychiatrist, and I took prescribed medicines. When I was dealing with the court, the letters were such a heart strength for me. I felt that I had support. In fact, the letters I took from the counsellor helped influence the judge's decisions and the verdict."

Mehdi

8.11. Importance of Person-Centred Care

The responsibility rests with healthcare service providers to understand the needs of the individuals involved and subsequently provide treatment that aligns with those requirements. Many participants conveyed that they believed the psychologist played a vital role in their personal development, and they recognised significant benefits from the psychologist's attentive presence and guidance in building mental resilience.

"In detention services, I was introduced to a psychologist, and then they found an Iranian psychologist for me. I was happy with how she clearly understood my problems and assisted me in a way that I still remember the service today."

Mehdi

"The psychologist is the best option for someone who is married. It proves the importance of that. We shouldn't think that now I'm single, so it's not useful, whether it did help me or not, and so on. There are specialist counsellors who are suggested by drug and alcohol workers, which means if I were an ordinary person, I don't know if I could find any therapist or not."

Ehsan

"I've visited a psychologist because of immigration pressures; I felt I needed to talk to someone."

Hessam

To achieve abstinence from substance abuse and attain sobriety, many individuals sought help from psychologists. They also received support through referrals to programmes such as Narcotics Anonymous (NA) and 12-step or 12-tradition programmes, which provided invaluable understanding of their challenges related to AOD. While some individuals benefitted from this approach, others found it to be ineffective.

"Thank God I met the NA program here. All those problems continue to occur, most of them, but I don't use drugs anymore."

Sajjad

"I was working on the principles of the 12-step programme, but I became increasingly confused, resulting in a loss of self-esteem and confidence" I don't enjoy going to NA meetings to hear about other people's problems; it distracts me and makes me feel down. Many individuals with numerous problems simply talk to support one another. If they were truly able to help each other,

they wouldn't be facing so many issues. Instead, I would prefer to be referred to a psychologist or counsellor, as they are specialists in their field, and I believe they can offer me the help I need."

Dara

The study indicated that the participants had a positive experience in collaborating with me. They gained benefits from this collaboration, as it helped them reduce their substance intake, largely due to our shared cultural and linguistic backgrounds.

"The only place that truly helped me was here. I may have sought help elsewhere, but I always left with the same dreadful feeling. When I came to you, I sensed that you listened. You consistently paid attention whenever I shared my struggles with marijuana and gambling. The moment I felt understood by you, it made a significant difference; now, it has been 2 years and 6 months since I last engaged in gambling, smoking, or any other addictions."

Hamed

During the focus group discussion, participants expressed that my involvement in counselling and treatment for mental health and AOD issues provided them with significant relief, as it represented a crucial milestone in their access to essential services. They shared how having a counsellor who could speak Persian fluently enabled them to feel at ease in seeking mental healthcare, as communication was no longer a barrier. One participant articulated:

"The NA programme helped me realise that I have a spiritual problem, and I should come and talk about it and, with your help, move forward. Now, due to the restrictions we face here, some individuals connected with a woman named Yalda, who in turn has linked us to a trustworthy psychologist. Something positive has emerged for me. She was the catalyst for the most

significant positive changes in my life. She introduced me to an Iranian female doctor who prescribed me medication. I was devastated, and my soul was in turmoil, a feeling that everyone understands. After starting these medicines, I felt calmer."

Abbas

The counselling services were provided in a language that the participants could understand—specifically, Persian rather than English—and by a counsellor with whom they shared a cultural background. The participants reported that this arrangement helped them grasp various issues related to mental health and substance use. It also facilitated diagnosis, and the counselling services were well received, enabling the participants to understand and implement measures that could improve their mental wellbeing and reduce their reliance on substances. These advantages stemmed from the shared cultural and linguistic backgrounds of the counsellor and the participants, who are Iranian male immigrants in Australia.

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My proficiency in Persian provides me with a comparative advantage over others, as I can effectively communicate and engage with individuals fluent in this language.

"May I say something about the counsellor? First, being in Persian is critical. You know why? Doing it in Persian gives you an advantage. Why? You have a knack for motivating us. An Australian psychologist is very different from an Iranian one. I mean, you push us many times. It's coming from knowledge; it's not based on a structure. It's because of cultural knowledge. I want to emphasise that communicating in Persian is very important.

Amir

Participants also said they were pleased to receive AOD counselling and professional support in a safe environment and to be referred to the appropriate services if they need it. They stated that because of their lack of knowledge and awareness, they were unable to ask for help and support from related services, like mental health support, relationship support, and social worker support.

It was suggested that there are notable distinctions between Australian psychologists and their Iranian counsellors. The participants believe that my lack of engagement with the regimented patterns is why they find me intriguing. I attribute this phenomenon to my awareness of cultural knowledge. Individuals strongly emphasised the importance of communicating in Persian. The participants expressed satisfaction with the provision of counselling for AOD issues, as well as the availability of professional support in a secure setting. For many participants, it was easier to develop a trusting relationship with a counsellor with whom they spoke the same language than with psychologists with an Australian background and cultural embeddedness. Additionally, they appreciated being directed to the relevant services when required. The individuals expressed that their limited knowledge and awareness of the Australian healthcare systems, due to the language

barrier, hindered their ability to seek assistance and support from pertinent services, such as mental health support, relationship support, and social worker support.

"The help I received here – and I believe you paid my forfeit once – and you should know that I suffered considerable harm in Australia. I endured significant injuries multiple times between 2015 and 2018. I had two accidents. On one occasion, I faced a serious attack, for which the court showed no consideration. I think you believe me here, despite the fact that my rights were violated, and no one ever exhibited any understanding towards me."

Hamed

The participants believed that in certain circumstances, individuals require support from those outside their immediate family and social circle. In this context, a counselling staff member must possess a certain level of expertise and the ability to provide appropriate guidance. Consequently, the participants recognised me as a counsellor with the necessary knowledge and capacity to fulfil a counselling role within the mental health and AOD field. Some participants noted my empathy and how I provided them with the opportunity to express their emotions. This process led them to feel more comfortable and satisfied with my services, allowing them to open up about their experiences.

The participants expressed their appreciation, as the counselling services I offered had a significant impact on their quality of life. While they were free to recount the hardships they were currently facing, they indicated that their life conditions had improved compared to previous experiences. Interacting with a counsellor who genuinely understands, and listens offered the participants a sense of companionship, which motivated them to pursue personal growth and improvement. They

took the time to thank me for my commitment to providing expert assistance where I could. Additionally, I referred participants to relevant support agencies after identifying healthcare and support needs that were beyond my expertise. One participant explained:

"I truly appreciate your empathy and the determination you showed in providing support during my visit. You not only showed understanding of my issues, but you even went a mile further to connect with an employment agency here in Sydney, which enabled me to secure employment. To a certain extent, your kindness helped me alleviate the anxiety and stress that I was going through. I really thank you."

Hossein

In addition, the participants stated how they found themselves in a highly detrimental environment where they felt that their personal well-being was neglected, which in turn contributed to their dependence on illicit substances. In response to this, they explained how they required an individual who could facilitate their self-awareness, goal identification, and the cultivation of a proactive mindset, thereby fostering their motivation to overcome challenges and enhance their overall quality of life. With my assistance, the participants were able to gain knowledge about self-care and rediscover their identities and potential. Participants could acquire self-assurance, aptitudes, and a diverse array of resources necessary for their livelihood. The outcome elicited a strong sense of happiness among them.

"Because I was a consumer, and I had a terrible situation: I didn't have self-love, and I didn't realise that I was human like everyone else. I learnt self-care during counselling sessions. I learnt how to find passion. Yes, recently I've understood that I like walking a lot. I haven't known

it for 40 years. I learnt about it during counselling. I'm learning self-care, discovering skills I didn't know I had, and exploring work that I didn't realise I enjoyed. Additionally, the regular counselling sessions provide answers to my challenges."

Amir

"I have decided to attend an NA program. I have been seeing a doctor for several years, but nothing has helped me. There seemed to be no door open to me. DAMEC is the only door that is always open. A lady referred me to the doctor, and she suggested a detox program. I understand that all other avenues have closed, and this is the only place that has truly cared for me without expecting anything in return. I have received a great deal of support from this place, and I humbly pray to God that this door remains open so that others like me can also find help."

Mohammad

A subset of participants expressed gratitude since they had been apprehended and formally accused, so they faced the potential imposition of a custodial sentence by the judiciary. However, I intervened by furnishing a letter of support on behalf of everyone, resulting in alternative dispositions, such as the imposition of good behaviour bonds or placement on parole within the community correctional system.

I had several legal issues, resulting in court sentences and appointments. I felt utterly disappointed and sad. I had no money and ended up borrowing from friends. I engaged the services of a lawyer, who warned me that jail was the likely outcome. My NA friends mentioned there was one person who could help me—this lady. Without any expectations, she referred me to

a detox program, and I attended individual and group sessions with her. She also provided me with a support letter, which contributed to my receiving good behaviour sentences. My parole officer told me I was fortunate that my counsellor had provided the letter. My entire family in Iran prays for me. You saved my life. I ended up going to jail. Now, I was neither sober nor clean, and God knows where I was at that moment.

Jahan

8.12. Assistance with Various Needs

Participants expressed their gratitude for the assistance I provided with various pressing issues, including immigration processes, communication with court judges, and the renewal of their driving licences.

They explained how the support letter I helped them obtain facilitated their access to decent housing, Centrelink services, and immigration-related matters. For those who had not yet secured their visas, I was reported to have been instrumental in resolving their visa-related issues with the appropriate immigration authorities. Some participants were even referred to psychiatrists and prescribed medications with my assistance.

Consequently, the participants viewed me as well positioned to offer the diverse types of support necessary to alleviate the anxiety and distress they experienced while navigating life in a foreign country. In this context, one participant, Saeed, explained:

"It is crucial to consider the level of awareness and knowledge that someone possesses when they offer to help you. I have encountered numerous experiences and received substantial

assistance. I do not hesitate to ask for help from others. I understand that lacking support is far more challenging than seeking help and acquiring new experiences.

Yalda assisted me when I required a referral to detox. She supported me with my immigration issues and court matters by providing support letters. She also helped me connect with a support worker when I needed assistance with my Centrelink payment. She also helped me with the fines I had accrued, which my visa issues and lack of employment prevented me from paying. Mentally, I was struggling, but she helped me by facilitating both group and individual sessions. She did everything within her power to support me. Staying sober is my way of making her happy."

Saeed

8.13. Helpful Therapeutic Processes

Most participants reported that engaging in individual treatment helped them understand the factors that led to their drug use. They felt a sense of sadness because they were unable to participate in the anger management, healthy relationships, and self-esteem groups during the lockdown period.

"The educational groups that you hold, like anger management, self-esteem, and healthy relationships, have been helpful to me, especially."

Mohammad

"It was in anger management where Yalda was holding for self-esteem, how to confront our fears and how to face our emotions. I think there were 7-8 meetings, and I participated in all of them. It was wonderful. I knew that DAMEC offered mental health and couples therapy groups and

services, and I have personally used these resources. I don't want to exaggerate, but personally it was such a help to me."

Sajjad

While working at DAMEC, I provided significant support to clients across various areas, including educational groups such as anger management, AOD relapse prevention, self-esteem, and healthy relationships, as well as therapeutic groups. I recall facilitating a range of therapeutic sessions focused on the experiences of Iranian migrants. I structured these sessions to foster the development of specific personality traits within Iranian migrants, particularly resilience and the capacity for self-care and self-love. The aim was to help Iranian migrants recognise the detrimental effects of illicit substance use and encourage them to abstain, as such use could lead to the deterioration of their physical and mental health.

Feedback from participants during the FGD reinforced this idea. They expressed that the group programs were valuable because they offered opportunities for connection and built close relationships with others who had similar experiences. The group programs facilitated the sharing and exchange of experiences among participants, aiding in their healing from the traumatic events they encountered on their journey from Iran to Australia, particularly during their time in immigrant detention facilities. During the FGD, Amir stated that:

"I cannot express the relief I experienced by participating in the group program you organised a few months ago. This relief is something I cannot compare to any services I have accessed, even in my home country where I grew up. In the group programs, we shared, reflected, and laughed together. We were able to release the difficult feelings and emotions we had; we felt empathy and

healing without any judgement. As a result, my negative thoughts, fears, and insecurities noticeably diminished."

Amir

8.14. Experience Working with a Female Counsellor

The participants expressed that it was pleasant and welcoming to receive counselling services from a female counsellor. However, I believe this comfort was not solely attributable to my gender but rather to my close connections with Iranian male immigrants, sharing a cultural and linguistic background. Throughout my academic and professional life, I have learnt that individuals tend to feel more at ease discussing their personal lives and experiences with someone of the same gender, particularly when they share specific experiences. Some participants suggested that my achievements as a female counsellor working with Iranian male immigrants indicated a certain level of experience. Nonetheless, I reassured myself with the understanding that experience encompasses knowledge and skills gained through direct involvement in various activities or a professional relationship with a female counsellor. Reza corroborated this sentiment by stating that:

"Look, when something is in my blood, I can't avoid it no matter how hard I try; I still have that shape as my true self. It's like speaking Persian, I can't say that one day I won't understand the Persian language. I hold the old belief and attempt to replace it with new approaches; however, in a stressful situation, my automatic self reverts to the old ways. I believe Yalda could make this connection and rapport with me not only because she is a Persian woman and can speak the Persian language but also because she understands our challenges as migrants as a person who worked with us and learnt about our needs and problems!"

Reza

Several individuals expressed their cultural perspectives about women, resulting in notable shifts in their attitudes and emotions.

"I thought I must behave harshly because you are a woman."

Behrouz

In Iranian culture, as a woman born in Iran and residing in Australia since 2014, I believe there is a prevailing notion that women are inherently weaker than their male counterparts and incapable of performing certain tasks, such as working with individuals who have mental health or substance use disorders. This belief may stem from perceived risks and dangers that female counsellors face when working with men who have mental health issues or substance use disorders.

Furthermore, despite their expertise and experience, many view women as incapable of providing services to men. However, this perspective has shifted significantly, both women and men are now recognised as suitable for counselling and capable of working in virtually all environments, including those traditionally dominated by men, as I have witnessed at DAMEC.

Although discrimination has largely diminished in various sectors, there are still beliefs among Iranian men and migrants that women are weak and incapable of fulfilling certain roles or working in specific fields, such as drug rehabilitation centres. This perspective complicates the feminist theoretical framework and the dynamics of gendered power, potentially having a detrimental effect on women migrants aspiring to secure positions in diverse organisations, thereby helping those in need and improving their own livelihoods in the process. Drawing on my

experiences as an immigrant and a female counsellor, I found this proposition to resonate deeply, a sentiment further corroborated by the focus group discussion.

"I saw this lady for the first time, with all the arrogance I possessed. She behaved and sat in front of me in such a way that it allowed me to set aside my pride, enabling me to express thoughts I had not shared with many others. Subsequently, this experience prompted me to reflect on my childhood and helped me uncover the untold secrets of my life, which were rooted in my pain. This lady played a significant role in my life, and I always keep her in my prayers."

Abbas

One emerging perspective is that participating in therapeutic sessions with female counsellors can help cultivate assertive communication skills, which may lead to increased respect within society. However, it is essential to emphasise that the therapist's gender, whether male or female, is largely irrelevant to therapeutic sessions. The most crucial factors are the cultivation of awareness and the acquisition of relevant knowledge. During the FGD, participants who recognised my proficiency in counselling skills and my diligent work underscored the importance of respecting career women, particularly those in counselling roles. This respect acknowledges their professional contributions and reinforces the value of diversity within the counselling profession. Ultimately, creating an environment that appreciates both genders in therapeutic roles enhances the overall effectiveness of the support provided to clients.

"Another aspect to consider is that when your counsellor is a woman, you must communicate more thoughtfully; it is important to prioritise polite behaviour and use respectful and

appropriate language. This experience has trained me, and now, whenever I interact with any woman in various situations, I conduct myself with respect."

Mehdi

It became apparent that the participants were initially hesitant about receiving counselling services from me as a female counsellor. However, after several counselling sessions and my interactions with them, they began to recognise that women possess a profound understanding of men's experiences. This insight allowed them to appreciate that female counsellors could be more effective in supporting men facing mental health issues and AOD problems compared to their male counterparts.

"When my friends introduced Yalda to me, I did not think, 'May I have a wonderful session with you?' I was simply expecting to have one session; I was convinced that I would not continue with counselling after that. However, it has been five years since Yalda became my counsellor. I have found her to be very understanding, helpful, and skilled in her work."

Kaveh

"People are different. Have you ever noticed how some children resemble their mothers, fathers, brothers, or sisters? Personally, I find it easier to connect with the words of women. For instance, there are many things I could not express to a man in the same way I have shared them with you."

Hamad

Before the FGD ended, several participants explained that receiving treatment services from a female counsellor was a better experience than they had imagined. Women have been

posited to be well suited in providing therapeutic services compared to men since gender is reportedly a significant determining factor capable of influencing the style and content of therapy. Further, women who work as healthcare professionals can communicate effectively, create rapport, and be easily trusted.

"Before coming to you, I visited various places and spoke to several psychologists, all of whom asked me whether I preferred a man or a woman. I used to say I preferred a man, but that changed when I met you. At first, I felt shy, but now I have this feeling… like, previously, I could only engage with the opposite gender when I was drinking. However, since I started seeing you, my self-confidence seems to have gradually returned, and now I feel alright."

Sina

Several individuals expressed feelings of distress and exhibited signs of emotional vulnerability, as they conveyed that their experience during therapeutic sessions with me evoked a sense of familiarity akin to spending time with their maternal figures or siblings.

"I mean it, but when I talked to you in one or two sessions, you gave me such a strong feeling of empathy that, frankly, you became like a sister to me. Every time we had a session, I was feeling like I was meeting my sister, and she understands me completely. I cried and laughed a lot with you, and I felt comfortable expressing my emotions.

Behrouz

"Because I have the experience that I can trust my mum very easily, I think a woman is like this." Because I know you wouldn't share this information, I feel comfortable talking to you as if you

were my mother or my sister. I can speak from my heart. I think I can get a connection effortlessly with a woman. I can have a conversation much more easily than with a man."

Mohsen

Initially, the Iranian male immigrants who referred them to me for counselling services lacked confidence in my ability to assist them as a female counsellor. They believed that I might not possess the "power" or strength necessary to help them with their mental health and AOD issues. However, over time, this perception changed, as the Iranian male clients began to recognise that I had the appropriate skills to support drug addicts and individuals facing mental health challenges in overcoming their difficulties. During the FGD, Ali, who spoke very little, remarked that:

"I should mention that you have the power, which ten men don't."

Ali

Following a series of sessions, a sense of a close and understandable professional relationship and trust begins to grow between the individual and me. The individuals found it convenient to express their emotions, feelings, thoughts, and experiences to the female counsellor, as they believed they would not face judgement and could receive assistance and support. But some participants had the opposite idea.

"Physically, in terms of movement and doing work, men tend to be more powerful. Women, on the other hand, are capable of thinking about multiple things simultaneously, while men often struggle with this. Consequently, men may appear more successful due to their ability to

concentrate, whereas women tend to be more effective in emotional matters. This is why I prefer to see a counsellor of the opposite sex."

Abbas

Furthermore, it was their conviction that I played a pivotal role in facilitating their noteworthy accomplishments. The individuals expressed a high level of satisfaction in receiving a variety of social and counselling services from me over the course of the previous years.

"Regarding the women I confide in, I can approach this lady to express my pain, sharing that they do not accept me or wish to befriend me because of my skin colour, my language, and my height. I feel rejected due to my background. I can turn to her and cry. When I try to share my feelings with them, they laugh at me, but this lady did not. She offered her support. I feel comfortable in your presence."

Abbas

"Generally, women have a great influence on men. A woman counsellor is better."

Shahram

8.15. Summary

This section presents the findings of my autoethnography for this study. As a female counsellor, it was essential for me to reflect on my memories and incorporate them in my research. I share certain experiences with those interested in my research, particularly as an Iranian migrant who relocated to Australia in search of a new beginning. Through autoethnographic writing, I have

given voice to my personal experiences, both as an Iranian female counsellor and in demonstrating the prospective experiences of Iranian women working with or serving men. Some participants, who took part in individual interviews, also contributed insights from focus group discussions to support my autoethnographic findings. Several themes emerged from these findings, which have important implications regarding the aims of this study.

The themes encompassed confidentiality issues between the counsellor and Iranian migrant men, as well as comparisons drawn between me and the participants. Additionally, both my autoethnographic writing and the perspectives of the participants revealed a tendency among Iranian migrants to exhibit disrespect towards and threaten female counsellors. Working with Iranian migrant men facing mental health challenges and drug dependency proved to be difficult. Some clients displayed aggressive behaviours, while others engaged in criminal activities, and a few even crossed professional boundaries by flirting with me.

Despite these challenges, some participants acknowledged the value of interacting with or obtaining services from mental health specialists. The likelihood of seeking mental health services may increase when a specialist delivers person-centred care. In this context, the participants recounted how receiving counselling from me was beneficial.

This process also involves communicating in a language (Persian) that they understand, which encouraged them to seek mental health services. Although I initially faced negligence and abuse from the participants, they ultimately expressed satisfaction with my services, as they found it easy to trust me and appreciated my empathy towards their experiences. I assisted the participants in addressing various needs, such as securing housing, processing their migration

documents, and renewing their driving licences, which helped alleviate some of the tension and anxiety they were experiencing.

Furthermore, the participants were pleased with the support I provided on several issues, including anger management, establishing healthy relationships, and boosting their self-esteem. Over time, they became comfortable interacting with a female counsellor, although this was not the case at the outset. Many participants initially perceived me as inferior and unworthy of their time. Several Iranian men who referred me to counselling were doubtful of my ability to provide effective services because I am a woman. Ultimately, the participants recognised that I possessed the skills and knowledge necessary for my profession.

9. Discussion

9.1. Introduction

In this chapter, I divide the key findings of the current study into two sections. The first section discusses the results of individual interviews, while the second section focuses on the findings from the autoethnographic research, which includes the researcher's autoethnographic analysis supported by focus group discussions. Following this, I will provide a description of the study's limitations and strengths, along with detailed suggestions for future research in the field of migrants' experiences.

It is important to note that in this study, the terms 'mental health issue' or 'outcome' refer to a position on the mental health continuum that reflects various negative consequences or feelings associated with specific events or circumstances encountered during the pre-migration, migration, or post-migration phases. Additionally, the term 'migrant' has been used interchangeably with 'immigrant' due to the negligible difference between the two. Furthermore, the phrase 'Iranian migrant men' specifically refers to the participants in this study.

9.2. Discussion of Individual Interview Results

9.2.1. Relationship Between AOD consumption and Mental Health

The present study's findings indicated a correlation between AOD consumption and mental health issues among the participants. In particular, the tendency to consume AOD was higher among those who had experienced psychological distress in different phases of migration. Although migrants come from various backgrounds, unfavourable situations in their home

countries can lead to distress and anxiety, which may drive them to engage in AOD consumption. This conclusion is consistent with recent studies, which have shown that mental health problems are risk factors for substance use problems (Swendsen et al., 2010; Solfrank et al., 2023). Different factors, broadly classified into pre-migration, migration, and post-migration, can mediate such a relationship.

By virtue of being forced migrants, the participants reportedly experience hardship and difficult situations, which are characterised by poverty, conflict, and the loss of loved ones. These traumatic events can contribute to mental health stressors that could trigger the risk of depression, PTSD, and other mental health problems that could, in turn, augment the risk of consuming AOD. For instance, studies have demonstrated that PTSD plays a significant role in substance use problems, particularly among migrants and asylum seekers (Horyniak et al., 2016). Similar to the current study's findings, Cantekin and Gençöz (2017) indicated that pre-migration traumatic events, such as the loss of loved ones, poverty, and political violence, were significant predictors of PTSD and anxiety among forced migrants, which predisposed them to consuming alcohol and other drugs. Further, it has been implied that higher levels of resource loss are also associated with higher levels of psychological problems, which predispose them to consuming alcohol (Cantekin & Gençöz, 2017). Due to coming from deprived backgrounds, this study showed immigrants are likely to consume alcohol. Although light drinking may be associated with enhanced mental, emotional and physical health (Moreno-Llamas & De la Cruz-Sánchez, 2023), having a history of consuming alcohol could also cause mental health problems. In this study, most participants reported that they had been consuming alcohol before they moved to Australia. Although the current study did not evaluate the correlation between alcohol use and mental health problems, the findings indicate that some participants who consumed alcohol before moving to Australia

experienced mental health problems, which in turn led them to start consuming beverages while in Australia. The findings align with a recent study by Abdu and Hajure (2020), which demonstrated a correlation between alcohol use disorders and mental health issues.

Additionally, as most participants migrated to Australia alone, leaving their families behind, they experienced loneliness, a lack of friends, depression, severe stress, and feelings of misery, which predisposed them to alcohol consumption. This issue was further exacerbated by lengthy periods of detention and challenging living conditions in migration detention centres. It was evident that loneliness and severe stress drove participants to consume alcohol and other drugs. Many are aware that loneliness is associated with increased alcohol consumption, and studies indicate that individuals struggling with alcohol and drug dependence often experience greater feelings of loneliness than others (Ingram et al. 2020). Experiencing traumatic events prior to migration may contribute to mental health stressors that heighten the risk of depression, anxiety, and other mental health issues, which could subsequently increase the likelihood of substance dependence after migration (European Monitoring Centre for Drugs and Drug Addiction, 2023). Notably, PTSD has been identified as a significant risk factor for developing substance use disorders, particularly among forced migrants, refugees, and asylum seekers in need of international protection (Horyniak et al., 2016). Conversely, alcohol consumption was linked to mental health issues, as some participants noted that drinking alcohol led to depression or exacerbated existing mental health problems. It has been suggested that alcohol use disorder co-occurs with mental health disorders, either sequentially or simultaneously (National Institute on Alcohol Abuse and Alcoholism, 2024).

Although individuals respond differently to psychological distress, the current study has identified that migrants facing mental health challenges often resort to alcohol and other drugs as

a coping mechanism. According to Specker and Nickerson (2019), refugees and asylum seekers frequently endure interpersonal trauma, including torture and persecution, alongside forced displacement and stressors such as family separation, settlement instability, and visa complications. Individuals from refugee backgrounds often experience significant suffering, trauma, and loss prior to their arrival in Australia. Consequently, these humanitarian entrants may encounter various emotional, psychological, and physical health issues. Their experiences can include torture, persecution, civil conflict, abductions, sexual abuse, bereavement, hunger, and disease (Refugee Council of Australia, 2019).

A recent study identified four categories of traumatic experiences among forced migrants and refugees in Australia: torture, widespread trauma, exposure to violence, and deprivation, along with a group characterised by low exposure (Nickerson et al., 2021). In contrast to those in the low-exposure category, individuals in the trauma-exposed group are likely to experience more persistent stressors and severe psychological symptoms. They also tend to be men, highly educated, from Farsi-speaking backgrounds, and have entered Australia by boat (Nickerson et al., 2021). While the study primarily focuses on examining the relationship between AOD consumption and mental health issues, it is important to acknowledge that pre-migration contexts can significantly contribute to mental health problems among migrants, as well as their AOD usage.

Further, existing evidence indicates that some immigrants may be vulnerable to consuming illicit substances due to experiencing adverse events in their lives, especially in the pre-migration phase (Horyniak et al., 2016). Consistent with this, recent studies revealed that migrants who experience premigration stressors such as conflict, poverty, separation from loved ones, loneliness, and depression are rendered vulnerable to substance use and may develop alcohol and drug

dependence as a coping mechanism for anxiety and psychological distress such as depression and PTSD (Hajak et al., 2021).

9.2.2. Migration

The relationship between AOD use and mental health problems also became evident during the migration process itself. For some participants in this study, the journey from Iran to Australia was traumatic and evoked distressing memories of travelling on a boat while navigating the Indian Ocean for several days. Although there has been limited research into the connection between the migration experience and mental health among immigrants, as highlighted by Carroll et al. (2020), this study found that the migration journey itself contributed to psychological issues among the immigrants. This finding aligns with recent studies that have demonstrated an association between migration and mental health symptoms (Bhugra & Gupta, 2011; Liao et al., 2023). It has been suggested that individuals who have been subjected to and are vulnerable to mental illnesses face an elevated risk of developing more severe psychological health issues during the migration journey. This underscores the notion that migration acts as a significant predisposing factor for mental health problems, primarily due to the various barriers and traumatic experiences that migrants encounter during their journey, which may continue to impact them even after the migration period (Bhugra & Gupta, 2011; Liao et al., 2023).

Moreover, Keller et al. (2017) discovered a robust relationship between pre-migration trauma events and post-traumatic stress levels. The authors discovered a causal relationship between pre-migration trauma and mental distress, including post-traumatic stress, gender, and family separation, among Sudanese refugees (Keller et al., 2017). This conclusion was also evidenced by a recent study by Schweitzer et al. (2018), which found that the number of pre-migration traumatic events experienced by participants was connected to rates of trauma

symptomatology, depression and somatic symptoms. As the current study's participants entered Australia, they moved into detention facilities with psychological distress experienced during the migration journey, which remained unaddressed due to lack of needed assistance. Moreover, the situations in immigration detention facilities augment migrants' risk of diseases, violence, and traumatic events. The deteriorating health of immigration detention centres can be attributed to a variety of stressors, including uncertainty about migration processes, the criminalisation of migrants, feelings of isolation, a lack of staff support, and communication barriers (WHO, 2020). The unaddressed psychological issues and deteriorating health, coupled with living in difficult situations in detention facilities characterised by limited access to medical help, unfair treatment, discrimination, visa problems, and uncertainty, predisposed participants to consume AOD as a coping mechanism. Further, the current study found that participants experienced anxiety and were increasingly worried about the possibility of dying in a foreign country or even being deported since they were in the country illegally. Such experiences led participants to consume AOD while in detention facilities. In line with the findings of this study, Pinedo et al. (2022) found that being fearful and worried about being detained indeterminately for illegal immigration reasons was related to higher odds of engaging in heavy drinking and consuming illicit drugs. Further, fears or worries about being deported for illegal immigration were associated with high-intensity drinking (Pinedo et al., 2022).

9.2.3. Post-Migration: Migrant's Detention and Mental Health

According to the findings of this study, the post-migration phase represents a significant period that exemplifies the peak of participants' mental health experiences and their consumption of AOD. Following their release from detention facilities, participants encountered psychological issues that prompted them to consume alcohol. The primary causes of psychological distress

identified among the participants included problems related to their visas, challenges in securing employment, feelings of loneliness, and difficulties in obtaining housing. Additionally, participants faced uncertainty concerning their visas and work permits, which, combined with communication barriers stemming from limited English proficiency, contributed to their psychological distress. This distress subsequently compelled the participants to turn to alcohol. Similar results have been found by Vasic et al. (2021), who noted that the challenges of moving and adjusting to a new country make it more likely for people to misuse alcohol and other drugs, like marijuana, cocaine, amphetamines, tranquillizers, and inhalants such as glue and gasoline. Although their study focused on youth and adolescents, it has been suggested that migrants are particularly vulnerable to substance use, as many of them have encountered post-migration stress and trauma, including loss of livelihoods, family separation, and uncertainty about their futures in a foreign country (Vasic et al., 2021). The situational factors present in the host country significantly impact migrants' mental health. Symptoms of depression, anxiety, and post-traumatic stress disorder (PTSD) have been associated with post-migration variables such as holding a temporary visa, uncertainty about visa status, lack of access to health services, and disconnection from the broader society (Verhülsdonk et al., 2021).

The gathered data indicates that settlement issues, such as difficulties in securing employment, may subsequently lead to AOD use among forced migrant men in Australia. Some perspectives shared by participants suggest that uncertainties about their future, feelings of loneliness, and experiences of underemployment or unemployment contribute to extreme stress. This aligns with previous evidence indicating that individuals with refugee backgrounds face significant challenges that expose them to various adverse social and health outcomes (Chen et al., 2017). Notably, obtaining suitable employment was a significant challenge; participants expressed

feelings of fear and anxiety due to the lack of appropriate documentation and uncertainty regarding their residency status. This finding is consistent with studies by Faris (2016) and Mutebi (2023), which revealed that certain immigrant groups, particularly those from Middle Eastern, African, and Asian countries, encounter considerable obstacles in securing employment while in a foreign country. These obstacles include a lack of recognition of their qualifications and prior work experience, issues related to their racial minority status, and complications surrounding their visa or legal status in their host countries (Refugee Council of Australia, 2019).

Furthermore, the lack of recognition of migrants' experiences and visa issues, coupled with the absence of culturally relevant employment services (Refugee Council of Australia, 2019), complicates the entire job-seeking process for migrants. These challenges, combined with discrimination faced by migrants, can hinder the job search and lead to unemployment or compel migrants to accept positions that do not align with their skills and experiences or to work under poor conditions. The COVID-19 pandemic exacerbated these issues, as participants reported that it became increasingly difficult to find employment opportunities during this period. Such experiences can significantly impact migrants' mental health, as illustrated by a participant in my study. Participants reported socioeconomic challenges that adversely affected their mental well-being. Specifically, participants shared that poverty and unemployment were prevalent issues faced by Iranian migrant men in Australia, which contributed to their marginalisation and impoverishment; this situation was often accompanied by poor mental health, compelling them to use AOD as a coping mechanism. Supporting this finding, Ballard et al. (2019) noted that migrants may resort to illicit substances as a means of coping with migration-related stressors, such as isolation, uncertainty, and negative emotions.

Similarly, Marquez et al. (2019) found that individuals experiencing stressors of migration, such as isolation and who have limited coping strategies, are likely to result in using illicit substances. A significant proportion of those using alcohol and other illicit substances use them as self-prescription to resolve the physical pain and psychological problems they experience every day, which may exacerbate addiction and other substance use problems (Marquez et al., 2019).

According to Costanza et al. (2017), the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) highlights that people who struggle in various areas of their lives, like having bad relationships and work stress, are more likely to face serious physical and mental health problems, as well as issues with alcohol and other drugs. Moreover, Costanza et al. (2017) provided an explanation of the association between substance use problems and the potential physical and mental health difficulties faced by forcibly displaced individuals. Accordingly, these challenges could lead to the excessive consumption of substances as a coping strategy to alleviate the anxiety and distress associated with social isolation and loneliness (Costanza et al., 2017) as described by participants in this study. Moreover, the feeling of being treated unfairly in different agencies and organisations in Australia, as described in the analysis chapter in this study, meant that migrant Iranian men were discriminated against, especially when accessing support related to social security. Ethnic minorities in Western nations are disproportionately represented in low-paying and unstable jobs, which may give rise to greater rates of workplace injuries and sickness presenteeism, which can have an important effect on both physical and mental health (Moyce & Schenker, 2018). In Australia, ethnic minorities are not sufficiently represented in high-level positions of authority, and they are at a higher risk of enduring psychological stressors in low-skilled employment (Daly et al., 2018). Consistent with the findings of the current study, previous reviews targeting the general population showed that there exists a significant relationship between

employment status and mental health problems such as psychological distress and depression, especially where individuals work in unfavourable workplace conditions (Hergenrather et al., 2015; Modini et al., 2016). Discrimination and racism are common stressors and social health determinants that impair social economic opportunities and have implications for harmful consumption of AOD, mental health issues and poor social outcomes (Mude et al., 2020). According to Saadi et al. (2020), both physical and mental health outcomes related to abuse, neglect, and poor conditions of confinement constitute social health determinants in immigration detention. Further, experiences of racism, discrimination and criminalisation are regarded as structural determinants of health that in turn influence migrants' experiences while also exacerbating health inequities (Saadi et al., 2020). The cause of these punitive confinement conditions in detention facilities is attributable to unfavourable detention policies, especially in western countries that receive significant numbers of migrants, refugees, and asylum seekers.

Such complex experiences, coupled with past trauma and mental health issues, could influence how Iranian migrant men in Australia engage with AOD consumption. In Australia, alcohol consumption is often viewed as a normal aspect of social life and is regarded as a pleasant social norm (Victoria Health Promotion Foundation, 2013). Although this study's findings did not explicitly demonstrate that participants were socially influenced by prevailing norms to indulge in AOD use, it is plausible that they resorted to excessive alcohol and drug consumption as a means of fitting in with the social norms of their new environment.

Alternatively, acculturative stress may have driven participants to begin consuming alcohol. The latter possibility is evident in the loneliness participants experienced due to language barriers, which hindered their ability to form meaningful relationships with members of the host society,

leading them to turn to AOD as a coping mechanism for their unbearable circumstances. A key part of the acculturative stress model is how the stress from not having enough support or coping skills while trying to fit into a new culture can negatively impact mental health (Choy et al., 2021).

Consequently, it has been established that there is a direct relationship between mental health problems and AOD consumption among Iranian migrant men, as the psychological distress, hardship, and trauma they endure may drive them to engage in AOD use.

9.2.4. Cultural Stressors and AOD Consumption

Cultural stressors refer to those factors that can potentially impact a migrant, particularly because they are perceived as 'foreign' due to cultural incongruence with the mainstream cultural context. This sense of foreignness and otherness experienced by immigrants has been identified as a primary cause of cultural stress and various mental health issues, including anxiety, depression, and PTSD. Individuals from migrant backgrounds encounter significant barriers in accessing mental health support, primarily due to the lack of cultural sensitivity and the absence of culturally appropriate services (Lau & Rodgers, 2021).

Furthermore, the failure to assimilate rapidly into Australian culture has been recognised as a key factor contributing to mental health challenges among Iranian migrant men. Numerous studies have highlighted how a migrant's inability or unwillingness to assimilate into the culture of the host country can pose significant difficulties (Henrich, 2019). This phenomenon can be understood through the assimilation model, which posits that immigrants adopt the customs and lifestyle of the host country (Ballard et al., 2019). The participants in this study faced obstacles in adopting

Australian culture and lifestyle, largely due to language barriers that hindered their ability to connect with local communities.

In specific circumstances, the assimilation model may also account for the tendency of migrants to adopt the substance use habits prevalent in the host country. However, this was not observed in this study, as participants did not exhibit any signs of being coerced into using AOD by Australians, potentially due to language barriers and their limited ability to engage with host communities.

9.2.5. Section Summary

In this section of the discussion chapter, I examined the results of the individual focus group interviews and compared them with existing literature. The findings indicated that forced Iranian migrant men experienced mental health issues, including anxiety, depression, and PTSD, with some turning to AOD as a coping mechanism. I explored these experiences across three phases: pre-migration, the migration process itself, and post-migration. Prior to their migration, these men faced mental health challenges stemming from poverty and conflict. Notably, many participants were already consuming AOD before migrating to Australia. Upon moving to a new country, they continued to use AOD as a means of coping with the difficulties they encountered in their host environment.

The migration journey itself proved to be arduous and served as a crucial predisposing factor for mental health issues among forced Iranian migrant men. The post-migration phase was particularly linked to mental health experiences, exacerbated by unfavourable conditions within migration detention facilities, as well as experiences of racism, discrimination, and limited access to essential healthcare services. Beyond the trauma associated with detention, Iranian migrant men

faced additional negative experiences after their release, including loneliness, a lack of necessary support and accommodation, and separation from family and close relatives in Australia. These adverse experiences often compelled migrant men to resort to AOD in an attempt to cope.

Many participants found it challenging to establish a new life due to insufficient employment opportunities, communication barriers, and restricted access to healthcare services in Australia, which could lead to distress or exacerbate existing mental health issues. Additionally, Iranian migrant men faced hindrances in seeking necessary mental health services due to their inability to speak and understand English and the stigma surrounding mental health problems. A cultural clash between Iran and Australia, characterised by differences in linguistic, cultural, and societal norms, further impeded effective communication between clients and healthcare professionals, complicating the diagnosis and identification of needed support for Iranian migrant men.

It is notable that Iranian migrant men reported not only negative experiences but also positive ones, particularly when receiving services from bilingual counsellors who shared a cultural background and could communicate in Persian. Participants expressed satisfaction with the mental health services they received from me, as I was able to understand and speak their language. I believe that female bilingual counsellors could be particularly beneficial for culturally and linguistically diverse (CaLD) clients. However, despite being preferred by CaLD clients, female counsellors can face significant challenges when working with migrant males experiencing mental health issues due to a lack of necessary resources and support.

Regarding therapy types, most participants expressed a preference for individual therapy, although some were content with group therapy programs. Psychologists and counsellors must

carefully select the treatment approaches that best align with their clients' specific conditions and needs.

9.3. Discussion of Autoethnography Results

In conducting the narrative autoethnography research, I relied on my memories of my experiences as a migrant from Iran, as well as my interactions with Iranian migrant men who had relocated to Australia and were receiving treatment services from DAMEC.

Consistent with the tradition of autoethnographic research, my primary source of data was my memory. I documented my story, which recounts my experiences as a female counsellor who has worked with Iranian immigrants. In addition to my narratives, I facilitated FGDs with several Iranian immigrant men to validate and enrich my experiences as both an immigrant and a female counsellor. My insights from this autoethnographic study are elaborated upon in the following paragraphs.

9.3.1. My Experiences as an Iranian Migrant and Working as a Female Counsellor

I relocated to Australia with the intention of gaining personal freedom, social respect, and equitable treatment for myself and my families. As an Iranian female who has received training in the treatment of mental health and addiction, my objective is to provide assistance and support to this particular population. I believe that persons who come from my cultural and linguistic heritage and who currently reside in Australia have not adhered to their cultural traditions and have had incorrect beliefs in Iran. They are now participating in a new society that has different and more open-minded ideas, and they are working towards personal development and peace. During the time that I worked as a mental health and AOD counsellor, I frequently discovered that the challenges, pressures, and difficulties that my clients encountered were similar in many ways to

my own personal troubles. All of the traumatic experiences that I went through from infancy through adolescence and into adulthood were brought on by oppressive circumstances involving and caused by other people, such as my father, brother, neighbours, co-workers, and ultimately my husband. When I started working, I had the hope that I would eventually achieve certain human and women's rights. Individuals from a wide variety of racial groups, cultural backgrounds, and language groups are welcomed in Australia, and they are provided with fundamental rights, healthcare, and educational opportunities. In a short amount of time, I was able to achieve secure employment with a company that offers services to migrant people in the mental health and AOD fields.

In the course of my professional life, I frequently interact with many clients who are in need of assistance and therapeutic interventions. The fact that I also gathered references from female challenges is something that should be mentioned in this context, although this aspect of the research has not been addressed. Having interactions with immigrant men, particularly those from Iran, was fraught with significant challenges, which occasionally led to feelings of annoyance and tension.

Men who made conscious efforts to assert their masculinity often held the belief that women are inherently fragile beings who should always fulfill subservient roles and submit to men's authority. For instance, at one point during a group therapy session that I was facilitating, a participant said to me, “Shut your mouth and remember I’m a man” (Kourrosh). Such sentiments made me feel inferior in front of the group. These remarks suggested that, despite their qualifications and professionalism, female counsellors still experience intimidation from male clients who are deeply entrenched in the belief that women are inferior.

The underlying premise is that women tend to be treated as sexual objects, especially in male chauvinist societies; they are physically and intelligently subordinate to men, and their key role in society is to support men. This characterisation can be more nuanced and elaborated based on a given society, country, culture, and politics and relates to the patriarchy system, which is designed in such a manner that it positions men at the top of the societal hierarchy. Such behaviours and beliefs ensure men acquire and hold all power.

The connotation that women are inferior mainly rationalises inequality, violence, and hostility as justifiable towards women. This mindset constitutes a key element that can influence the effectiveness and health of female counsellors when providing counselling services to male clients. This concept is especially critical to comprehend in the context of the current study since it emerged that female counsellors may be subjected to unfavourable treatment by male clients.

To minimise the negative impacts associated with these beliefs and behaviours, feminist activists advocate equality for all genders in social, personal, and economic aspects. Various movements such as the feminist women's health movement empowered women's awareness about their health and fought against oppressive and paternalistic practices in health care systems (Shai et al., 2021).

With feminism, male clients understand that female counsellors can effectively deliver counselling services to clients of any gender, provided they adhere to professionalism. However, female counsellors need to understand male clients may not be initially receptive to them, but with time they come to appreciate the importance of female counsellors.

Confronting male clients may not always be suitable for the effective delivery of counselling services. However, it is essential for female counsellors to develop empathy and

effective communication skills when working with male clients, ensuring that they recognise that women can also be qualified to provide counselling to men.

Upon migrating from Iran to Australia, these individuals brought with them a history heavily influenced by patriarchal norms. After relocating, they encountered significant challenges in reconciling and integrating their damaging beliefs, leading to family issues, as well as difficulties related to mental health, substance misuse, and legal matters.

Due to the severe circumstances surrounding their mental health and a AOD issues, individuals were required to participate in educational and therapeutic programs in compliance with legislative mandates. Those resistant to change, who held a strong belief in their superiority as men from an early age, were often unwilling to explore new opportunities. Additionally, limited English proficiency, a common challenge among many Iranian men, sometimes resulted in individuals expressing a preference for male counsellors. This reluctance stems from deeply entrenched cultural beliefs and rigid attitudes that hinder openness to learning new languages and pursuing personal development.

In the fields of mental health, psychology, and addiction, there exists a notable shortage of counsellors who are proficient in multiple languages. Iranian men were often hesitant to accept my counselling services, with some expressing difficulty in trusting a female counsellor. This situation was a challenging experience for me as a female practitioner. This aligns with the findings of Patel et al. (2018), who noted that trust can be a significant issue, particularly among migrants and refugees who have faced repressive experiences, especially during the asylum process, often resorting to secrecy as a survival strategy. In this context, it is essential for female counsellors to clarify to migrants that they are not part of the asylum process and bear no responsibility for the suffering endured during it.

To enhance clients' understanding of the effects of culture and dysfunctional beliefs, I employed culturally relevant approaches and facilitated group therapy sessions focused on anger management, healthy relationships, and self-esteem. The data from participants' interviews, alongside my insights from the autoethnographic findings, indicate that clients became eager to effect changes after just a few sessions and were motivated to continue their therapeutic journey.

The participants in the counselling sessions made efforts to adhere to their patriarchal religious beliefs. Their conduct, at times violent and disrespectful, was a source of frustration for me. When faced with such behaviour, the established rules and standards within the counselling profession and its affiliated groups gave me a sense of security. As a counsellor, I endeavoured to exhibit empathy and provide non-judgemental support. However, my calm demeanor—unbeknownst to me—may have inadvertently conveyed indifference towards those in need of assistance. Some clients have commented on my perceived lack of respect, attributing it to my frequent failure to demonstrate civility, such as bowing and my tendency to prioritise my own needs over those of Iranian men.

Clients occasionally solicited illegal assistance from me, sometimes even persuading me to accept bribes in exchange for their help. They would invite me to restaurants or coffee shops and present me with gifts under various pretexts to encourage compliance with their unlawful demands, particularly when I did not meet their expectations. I consistently endeavoured to clarify the laws and regulations throughout this process; however, I regretfully received negative feedback. My position was ultimately unfavourable, despite my commitment to upholding ethical and moral principles in my professional career. Consequently, I faced threats, insults, and assaults, which are unfortunately all too common for women in Iran and are typically perpetrated by men.

As a female counsellor, I navigate a complex array of emotions stemming from the challenges posed by my profession and the legal restrictions that govern it. These emotions can be intricate and difficult to manage. Having experienced gender-based violence in my country, I have struggled to maintain a healthy work environment while grappling with past traumatic experiences. This has caused me to worry about my and my family's safety and my physical and mental health.

The Iranian community in Sydney is small, and I have always harboured fears about encountering individuals from this community who might be abusive towards me, my family, and our home, particularly due to my refusal to conform to their illegal expectations. As a woman of Iranian descent, I firmly believe in advocating for the protection of my rights. The pursuit of human rights, gender equality, and personal independence were the key motivations behind my decision to relocate. These considerations led me to conclude that it was vital to leverage my authority and the nature of my work as a counsellor to effect change for vulnerable individuals grappling with mental health and substance abuse issues.

The analysis of participant interviews revealed that numerous Iranian men expressed satisfaction with collaborating with me as an Iranian female counsellor, feeling a sense of trust and familial connection akin to being with their own family members, such as parents, sisters, and other siblings. The data on trust and respect revealed by the participants differed significantly from my experience. Initially, it was challenging for me, as an AOD and mental health counsellor, to establish open and honest communication with clients about their mental health and AOD issues, which made them feel stigmatised. Their experiences with their spouses in Australia triggered feelings of stigma and challenged their core belief that they are not equal to women and are of a higher status. My experiences confirmed my expectations about clients working with a bilingual counsellor from the same culture and language, as well as their willingness to work with an Iranian

counsellor on their AOD and mental health. Some participants agreed that having a bilingual counsellor who could speak their language and understand their culture encouraged them to participate in the counselling sessions. Crookston et al. (2018) state that language can significantly impact the professional relationship between counsellors and clients, highlighting the necessity for bilingual counsellors to understand the complexities of diversity and multiculturalism inherent in these relationships (Ratts et al., 2016). As they advanced through the FGD, their evolving opinions and core beliefs about women appeared to influence their emotions. During the interviews, they found the group sessions and counselling to be beneficial in helping them change their habit of using AOD as a coping mechanism for mental health issues, such as trauma, PTSD, migration, settlement in a new country, and experiences in detention services. In the literature review and results chapter, it was noted that Iranian migrant men find it challenging to seek help and support for AOD and mental health difficulties. They tend to assume that only NA groups and meetings can be beneficial for them. It is disheartening for them to seek help from an Iranian female in any circumstance. The previous studies found that Iranian men are reluctant to seek help for their mental health and substance use issues. The reasons provided by the previous researchers in their study are consistent with the outcomes of FGDs with participants, literature reviews, and other studies. The positive impact of seeking help on their mental and physical health, well-being, relationships, and life progress can be attributed to counselling sessions and group therapy provided by organisations like DEMAC, which offer various forms of support to clients dealing with mental health and substance use issues.

Very few FGD participants who were not my clients and had worked with other healthcare providers reported feeling safer working with male counsellors rather than female. This preference for male counsellors could indicate that counselling sessions with a female counsellor from the

same cultural and linguistic background might be beneficial for my clients. This familiarity could help address issues related to lifestyle changes, healthy lifestyle, mental and physical health, and healthy relationships with family, colleagues, and friends in a new country. This approach aims to prevent feelings of isolation and promote acceptance in the new environment.

9.3.2. Section Summary

In this chapter, the discussion revolves around me as an Iranian female who initially moved to Australia with the goal of achieving independence and recognition. Specialising in mental health, I aim to assist individuals from my cultural background. However, navigating my own personal traumas, intertwined with my clients' struggles, presents challenges. Cultural misconceptions hinder my adaptation to new societal norms, particularly when engaging with migrant men from Iran, highlighting entrenched gender biases and the need to address outdated beliefs, especially in cases of domestic abuse.

Transitioning to a new country requires significant behavioural shifts, especially ones rooted in patriarchal norms. Legal implications arise as individuals resist change, leading to clashes with societal conventions. Miscommunication, resistance, and hostility towards female counsellors further complicate the counselling process, particularly when working with Iranian immigrant men. Language barriers, limited English proficiency, and deep-seated gender biases hinder progress for Iranian immigrant men.

The counsellor faces challenges such as distrust, resistance to change, and clients' legal issues while also dealing with confrontational behaviour and manipulation attempts. Clients who push boundaries and use coercive tactics expose ethical dilemmas. Drawing on her personal trauma and her advocacy for women's rights, the counsellor experiences emotional turmoil and threats that

reflect broader societal issues. Striving for a balance between professional duties and personal well-being, I confront complex emotions while advocating for my safety and beliefs.

9.4. The role of Bilingual counsellors

9.4.1. Challenges of female counsellors

One of the themes that emerged from this study was the challenges faced by female counsellors when providing services to Iranian migrant men. Bilingual counsellors who offer counselling services can expect to encounter various challenges. While the challenges experienced by counsellors working with migrant clients have been explored in numerous studies from the perspective of professional counsellors and therapists (Kekki & Linde, 2022), the findings of this study are distinctive in that they examine the issue from both the researcher's and participants' perspectives. The results indicate that when delivering counselling services to Iranian migrant men, bilingual counsellors may face challenges such as flirting, being mocked for their gender, trust issues, and even threats from male clients, particularly those grappling with mental health and AOD use problems. This finding connects to the broader theme regarding the difficulties female counsellors encounter when attending to male clients. As noted by da Silva Rebelo et al. (2018), immigrants and refugees often experience feelings of mistrust, hostility, and anger towards mental health professionals, stemming from factors such as poverty, social exclusion, and anxiety related to the fear of deportation and discrimination within healthcare systems.

Furthermore, previous research reveals that counsellors working with forced migrants face numerous challenges, including a lack of available resources, the complexities involved in collaborating effectively with other organisations, language barriers, difficulties when working

with interpreters, potential mistranslations, and the inconsistent meanings that can arise across different languages (Roberts et al., 2018).

However, these challenges should not be a reason to stop female counsellors but rather an opportunity to establish a healthy therapeutic relationship with clients experiencing mental health issues or AODs. The results of a study by Chen et al. (2021) underscore the need for bilingual and bicultural researchers and counsellors to establish trust and rapport with immigrants and ethnic minorities and expand access to mental health services.

9.4.2. Providing Culturally Responsive Care

Although the challenges faced by the participants may be similar, this study underscores the importance of counsellors understanding the specific needs of these participants to provide culturally responsive care. The findings reveal that language barriers and cultural insensitivity from healthcare professionals, who often act as gatekeepers to health care systems, contribute to mistrust and a reluctance among migrants to seek medical services.

Initially, participants in this study were hesitant to approach medical and mental health services provided by non-bilingual counsellors. However, upon discovering that I could speak their language, they felt more at ease and were willing to share their challenges. This openness facilitated my ability to diagnose mental health issues and substance use problems as a bilingual counsellor.

It is essential for bilingual counsellors to prioritise cultural competence, as this is a vital factor in fostering a positive therapeutic experience and can significantly influence migrants' willingness to seek counselling services (Lee et al., 2021).

This study indicates that bilingual counsellors, particularly those who can speak and understand the language of migrants, are adept at establishing effective therapeutic relationships with their clients. Posselt (2017) notes that AOD counsellors who share ethnic and linguistic backgrounds with forced migrants and refugee clients can build trust more easily. Bilingual counsellors frequently act as the initial point of contact for addressing mental health and AOD issues, as individuals who have been forcibly displaced often feel more comfortable sharing their concerns with those who speak their language and understand their culture. This aligns with the assertions of Slobodin et al. (2018), who emphasise that culturally sensitive therapy can significantly benefit migrants facing psychological challenges.

However, even when interpreters are available, they may not suffice to ensure adequate access to mental health services. According to Pandey et al. (2021), language is only one of several barriers that migrants encounter when seeking mental health assistance; concerns regarding stigma and confidentiality associated with cultural perceptions of mental health issues can also deter them from seeking help.

In such contexts, I contend that bilingual counsellors who understand the language of Iranian migrant men can play a crucial role in addressing their mental health challenges and issues related to AOD use and addiction.

9.4.3. Connecting clients to Needed Support and Assistance

The study demonstrated that counsellors must provide migrant clients with essential support and assistance. Linking migrants to services such as housing, employment, and legal aid can significantly alleviate anxiety and psychological distress, as well as diminish the likelihood of their involvement in the consumption of AOD. While these services may not be directly aligned

with counselling, bilingual counsellors should remain attentive to the broader needs and issues that may exacerbate migrants' mental health challenges and seek ways to address them.

In my experience, I assisted participants with various needs, including housing, employment, and legal services, by referring them to relevant agencies. I also directed participants to psychiatrists to ensure they received the necessary support for their diverse requirements. During individual sessions, participants expressed their gratitude for my assistance in facilitating their access to a range of resources, including a day programme, detox programme, psychologists, psychiatrists, methadone therapy, and a mental health institution.

As noted by Siddiq and Rosenberg (2021), it is crucial for counsellors and psychiatrists to advocate for the enhancement of care for migrants and refugees, which should include the integration of social services within primary care settings, collaboration with community-based organisations to improve continuity of care, and advocacy for the various services and resources required by migrants and refugees.

Furthermore, it is vital for bilingual counsellors to challenge policies that may adversely affect the mental health of immigrants and refugees, even if such advocacy appears beyond their immediate responsibilities (Siddiq & Rosenberg, 2021).

Moreover, the findings of this study emphasise the need for bilingual counsellors working in Australia to understand the role of AOD use and the interaction between factors such as poverty, unemployment, separation from family members, and mental health issues. There is rich literature demonstrating the association between unemployment and prevalence rates of substance use problems involving divergent psychotropic substances (Nolte-Troha et al., 2023).

According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2023), some migrants may be more likely to use illicit substances after arriving in their host country for various reasons, including unemployment, trauma, poverty, and lack of social support. Migrants may result in using illicit substances as a coping mechanism due to their experience of boredom, trauma, frustration, and uncertainty as pertains to their immigration status (EMCDDA, 2023).

Therefore, bilingual counsellors must recognise the importance of addressing not only mental health issues but also other factors such as unemployment, poverty, and anxiety that may exacerbate mental health problems among Iranian male migrants living in Australia.

9.4.4. Providing Person-Centred Care

The current study highlights the necessity for bilingual counsellors to design and deliver counselling services to immigrants in a culturally sensitive and person-centred manner. Participants expressed dissatisfaction with Australian psychologists who were unable to understand and communicate in their language (Persian). They raised concerns regarding difficulties in diagnosis, inappropriate treatment, and negative experiences, which ultimately resulted in their overall dissatisfaction with mental health services.

A review by Filler et al. (2020) indicates that person-centred care is an effective approach that can improve client experiences and outcomes. This improvement is attributed to the fact that migrants tend to feel more confident and are more likely to trust counsellors who are familiar with their cultural backgrounds.

According to Procter (2016), offering person-centred and culturally appropriate health care and counselling services during counselling sessions is a crucial path for counsellors to pursue, as

it fosters trust not only upon their arrival but also during their long-term residence in the host country.

9.4.5. Effective Therapeutic Strategies

The findings from this study highlight the urgent need to adopt effective strategies to address employment-related mental health issues and the inequalities faced by Iranian migrant men in Australia. Of particular importance is the necessity to destigmatise mental health concerns, which hinder help-seeking behaviour among this demographic.

Previous studies have documented the experiences of stigma among immigrants and their reluctance to seek help, indicating that the stigma associated with seeking treatment for substance use and mental health issues serves as a significant barrier preventing migrants from accessing treatment programmes. Notably, Douglass et al. (2022) reported that stigma is a major obstacle to obtaining mental health services within immigrant communities.

Participants in the study indicated that mental health issues are often perceived as signs of weakness, personal flaws, shame, or a lack of willpower, leading to ambivalence regarding timely help-seeking. Due to fears of disclosing their problems to healthcare professionals and concerns that they may be dismissed, migrants frequently delay or altogether forgo treatment (Salami et al., 2019; Yorke et al., 2016). This phenomenon can be attributed to cultural stigma arising from the differing perceptions of mental health issues and substance use between Iranian and Australian cultural contexts.

Additionally, cultural stigma often accompanies negative emotions, resulting in heightened feelings of anxiety among migrants living with mental health problems. This includes fears of being labelled as ‘dangerous’, ‘crazy’, or ‘mentally ill’, which may lead to reluctance in seeking

help for fear of being turned away (Carpenter-Song et al., 2010; Yamada et al., 2019). Such circumstances frequently lead to frustration and a decline in self-confidence, causing individuals to perceive themselves as weak, unworthy, or even as failures with poor moral character (Martinez Tyson et al., 2016).

To cope with these stigma-related issues, immigrants often resort to denial and isolation, concealing their mental health challenges and turning to illicit substances, including alcohol and other drugs (Yamada et al., 2019), as illustrated by the participant in this study. The tendency of Iranian migrant men to hide their mental health problems and their reluctance to seek mental health services can be understood through the lens of social constructionist theory. This theory posits that men engage in the process of forming their masculine identity, which can involve denying pain and suffering. This denial hinders their ability to acknowledge their vulnerability and need for assistance. Research has indicated that some individuals may deliberately steer conversations away from topics that provoke strong emotional reactions, thus concealing any potential mental health disorders they may be facing (Rogers & Pilgrim, 2021).

Previous research has highlighted a potential correlation between the self-recognition of trauma and the likelihood of seeking care among individuals who have been forcibly displaced. In this context, Mond et al. (2020) reported that over 50% of forced migrants recognise that they are experiencing mental health issues; however, fewer than 33% actively seek assistance for these problems. Consequently, bilingual counsellors must work to destigmatise mental health issues among Iranian migrant men and assist them in understanding that such problems are not indicative of weakness.

While it is essential for counsellors to assist migrant clients in recognising that mental health conditions are classified as diagnosable and treatable disorders under the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), it is equally crucial to acknowledge that this perspective represents only one dimension of mental health (Üstün & Ho, 2017).

The medical model centres on diagnosis, pathology, and treatment—often through clinical interventions, which can be effective in legitimising psychological suffering and ensuring access to services. However, this approach may not resonate with everyone, particularly individuals from migrant or culturally diverse backgrounds, who may possess differing beliefs regarding wellness, distress, and healing.

To deliver more culturally responsive care, mental health practitioners should also contemplate recovery-orientated approaches that emphasise personal meaning, resilience, social connections, and the individual's goals for well-being. Recovery models do not define individuals solely through the lens of a diagnosis; instead, they focus on strengths, self-determination, and holistic support (Anthony, 1993). This perspective can be particularly beneficial for migrant populations, as it accommodates cultural narratives, community-based healing, and lived experiences in shaping the recovery journey. By integrating both medical and recovery-based approaches, a more inclusive, empowering, and culturally sensitive model of mental health care can be developed.

9.4.6. Female's suitability of working as counsellors

Although the current study did not explicitly identify any strengths associated with the gender of a counsellor, participants believed that female counsellors were particularly well-suited

to providing health assistance. Many expressed a preference for working with female counsellors because of their empathy, rapport, understanding, and ability to evoke feelings of care reminiscent of those of their mothers and sisters.

Female counsellors appeared to establish trustworthy therapeutic relationships with male clients more easily, leading to greater comfort and openness in expressing their experiences and emotions (Cotter et al., 2023). This aligns with findings from a recent study indicating that many clients favour female counsellors who are perceived as nurturing, caring, and understanding (Kamunyu et al., 2021). This preference may help clarify the over-representation of women in the counselling profession. A limited body of literature highlights that women dominate both the counselling and education fields (Chaney et al., 2019). A report by the National Centre for Education Statistics (2018) revealed that in the 2016-2017 academic year, out of 11,267 master's degrees awarded, 9,328 were conferred to females, while only 1,939 were awarded to males. Additionally, of the 353 doctorates in counsellor education, school counselling, or guidance services, 238 were granted to women, leaving 115 PhDs awarded to men.

To a certain extent, this finding may contribute to enhancing equality within the counselling profession, particularly concerning migrant men facing mental health issues and substance use problems. Although they may encounter initial challenges, female bilingual counsellors must remain resolute in demonstrating professionalism and fostering trust with migrant clients instead of giving up. This mindset embodies the principles of feminist theory, which posits that recognising and addressing gendered power and oppression can facilitate change and advocacy (Egbert & Roe, 2023).

9.4.7. Helpful therapeutic processes

Another theme that emerged from this study is the importance of helpful therapeutic processes. Therefore, bilingual counsellors must focus on therapeutic methods that are considered beneficial for migrant clients. This includes providing services that help migrants overcome their fears, build self-esteem, and promote safe and respectful communication, even in situations where the clients may not exhibit respect. Furthermore, it is vital for counsellors to be knowledgeable about which counselling therapies are appropriate for migrant clients.

When addressing the mental health challenges faced by migrant men and their consumption of AOD, counsellors can use various treatment modalities. These encompass both individual and group treatment therapies. According to Shealy (2009), these two modalities are identified as distinct forms of counselling or psychotherapy, each aimed at addressing psychological issues and facilitating behavioural modifications.

Individual treatment therapy is characterised by a mental health professional engaging with the client one-on-one at regular intervals to assist them in improving their emotional well-being, managing mental health conditions, and developing coping strategies in response to various life challenges (O'Donnell et al., 2020). The therapist assists the client in understanding and managing their thoughts, feelings, and behaviours in a secure and confidential environment. This personalised approach to mental healthcare can significantly enhance individuals' emotional and mental well-being.

Group therapy is regarded by some clients as second best after individual therapy, whereas some mental health workers refer to group therapy as intimidating to conduct. Our client's agencies and mental health care centres commonly use group therapy to treat individuals with severe mental

health issues. Although individual therapy may have its strengths over group therapy, especially for migrant men who sometimes conceal their mental health experiences and AOD issues due to possible stigma, group therapy has been shown to be highly effective in facilitating positive changes in individuals' lives. Group therapy has been identified as an efficacious treatment modality that can effectively facilitate clients' motivation to make significant positive changes in their lives (Esmaeili et al., 2018; Shealy, 2009).

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Group psychotherapy has been demonstrated to be as effective as individual therapy for various issues, including anxiety, sadness, grief, eating disorders, and schizophrenia (Burlingame & Strauss, 2021). In addition to alleviating symptoms, group therapy provides participants with a sense of belonging, purpose, hope, altruism, and meaning throughout the therapeutic journey (Yalom & Leszcz, 2020). This sentiment resonates with the opinions, beliefs, and perceptions of participants in this study, which indicated that group programmes are increasingly beneficial as they offer essential connections and a platform for interaction. These interactions enable fellow migrants to share personal experiences and learn important lessons from one another.

With this in mind, I propose that it is essential for mental health care professionals and counsellors to carefully select a treatment approach that aligns with the needs of immigrants and their specific circumstances. It is crucial to first ask the client about their preferred treatment modality, as their choice can significantly influence the success of the therapeutic process in mental health care services.

9.5. Limitations, Strengths, and Future Directions

In this section, I provide an analysis of the limitations and strengths inherent in the current study, followed by recommendations for future research endeavours. It is important to highlight that the proposals for programs, therapies, and interventions discussed in the preceding section were derived from a study conducted with a sample of Iranian men who were forcibly displaced.

These individuals, forced migrants from Iran, possessed distinct cultural and demographic characteristics. Most of the forced immigrants arrived in Australia by boat, were subsequently incarcerated in Australian detention camps, and eventually found temporary settlements in the city of Sydney. Therefore, I was required to evaluate the recommendations thoroughly before implementing them for forced migrants from diverse backgrounds or individuals residing in other states, territories, or nations.

Further, it was imperative that I consider supportive organisations when assessing the range of assistance available to forced migrants across different Australian states and territories. The individuals who were forcibly displaced from Iran, as observed in the present study, originated from a socioeconomically diverse background in their country of origin. In certain instances, these individuals possessed a limited or moderate level of education, as well as low professional abilities and limited work experience. Therefore, I needed to take these factors into account when applying

the current research findings, as they significantly influence the aspirations and actual experiences of Iranian forced migrant men.

In general, the outcomes of qualitative methodologies are not intended for extensive generalisations, and it is important to note that this characteristic should not be perceived as a limitation (Smith, 2018).

Especially within the context of contemporary research, this study represents my initial endeavour to do exploratory qualitative longitudinal research involving men who have been forcibly displaced.

Nevertheless, the outcomes of the individuals are consistent with prior research conducted on forced migrants originating from diverse cultural backgrounds (Pejušković & Vukčević, 2020; Gondek & Bernardi, 2003).

In light of the aforementioned limitations, in this study I implemented several measures, as recommended by Merriam & Tisdell (2016), to enhance the credibility and reliability of the research findings. Initially, the use of reflexive information served the purpose of enabling me to acknowledge and set aside my personal prejudices. Additionally, it enhanced my consciousness regarding the possible adverse effects that may arise from prolonged engagement with sensitive and painful facts.

Moreover, the process of member verification was implemented to afford Iranian forced migrant men the option to review and perhaps modify the gathered data with the objective of ensuring its accuracy. Furthermore, the inclusion of a supervisory review procedure allowed me to engage in meaningful discussions on the research process and ensure the alignment between data

collection, analysis, and interpretation (Merriam & Tisdell, 2016). In addition to possessing a notable degree of credibility, this research exhibits several prominent strengths.

First, by employing a phenomenological technique alongside a qualitative design, this study aimed to enhance understanding of the various factors that influence the process of meaning-making among forced migrant men as it evolves. The characteristics of the participants strengthen the current research. This study investigated the lived experiences of a substantial cohort, adhering to the recommended sample size for qualitative research designs (e.g., Flick, 2007; Sarfo et al., 2021). Moreover, the participants comprised Iranian men who had undergone forced displacement, exhibiting a variety of demographic traits and differing durations of migration. Notably, all participants had encountered challenges related to AOD use as well as mental health issues prior to their forced migration journey. The existing literature has not thoroughly examined this unique combination of traits.

My cultural background as the researcher also serves as an advantage in this study. Given that this research specifically targeted Iranian forced migrants, it was anticipated that many of these men would have limited proficiency in English. As a result, conducting focus group interviews in English may have led to communication challenges, which could cause misunderstandings for both the researcher and the Iranian forced migrant men. Since the researcher shares the same nationality as the Iranian forced migrant men, interviews can be conducted in Persian. It is hypothesised that the researcher's Persian heritage may facilitate greater openness in communication among the Iranian forced migrant men.

Future research must use a qualitative approach to fully understand the range of consequences associated with forced migration among men. By employing this comprehensive

methodology, future research endeavours would be able to elucidate the associations between adverse and favourable outcomes among Iranian men belonging to various cohorts of forcibly displaced individuals. Moreover, it is important to note that further qualitative studies are necessary to gain a more comprehensive understanding of the significance of the forced migration experience across various samples and populations.

Using mixed-method research approaches can be helpful for future studies because it brings together the strengths of autoethnography and qualitative analysis to better understand the topic (Creswell & Poth, 2016). Also, a future study that examines changes over a long period could enhance our understanding of how both the positive and negative effects of forced migration evolve over time.

10. Conclusion

Migration, while not a new phenomenon, remains a challenging life experience for migrants, especially those who face forced displacement. The impact of migration on mental health, along with an increased propensity for substance use among immigrants, highlights the urgent need for appropriate mental health counselling services to enhance their wellbeing. However, there is a significant lack of focus on the experiences of Iranian men regarding substance use, as well as the mental health issues they may encounter and their reluctance to seek help.

Previous sections of this thesis have shown that existing research predominantly emphasises the negative consequences associated with forced migration. As a result, there is a lack of awareness concerning the traumatic events faced by Iranian men who have been compelled to migrate and how these experiences may influence their mental wellbeing and use of addictive substances.

This study was designed to explore the experiences of Iranian migrant men facing mental health challenges and their use of AOD. It aimed to achieve its key objectives from both the perspective of the Iranian migrant men and the researcher by utilising autoethnography as a methodological approach.

The research employed a social constructivist and feminist theoretical framework to highlight the profound effects of migration, isolation, and double displacement on Iranian forced-migrant men who engage in drug use in the Australian context. I have stressed the material, social, and emotional repercussions of these experiences for the participants, asserting that these factors have exacerbated their substance abuse and associated mental health issues.

The present thesis aims to employ a qualitative and autoethnographic research approach to investigate the intersection of AOD issues and mental health counselling among Iranian forced migrant men residing in Australia. The study consisted of two phases.

The first phase used IPA and involved individual interviews with participants recruited from DAMEC records. The second phase consisted of an autoethnography that incorporated participants' perspectives on mental health counselling services within the Australian context. This autoethnographic study illustrates the importance of examining the complex relationships among gender, culture, language, and AOD consumption, as well as their impact on the mental well-being of forced Iranian male immigrants in Australia.

Several findings emerged from this study, including documented evidence that exploring AOD and mental health counselling with migrant Iranian men in Australia is a pertinent and significant area of research.

This study revealed a connection between the migration experience and the tendency of Iranian forced migrant men to use illicit substances and other drugs, as well as their struggles with mental health issues such as depression, PTSD, and anxiety. This relationship also highlights their reluctance to seek support for improving their mental health and for reducing their consumption of AOD as a coping mechanism. Migrant Iranian men are more likely to encounter various mental health challenges due to the traumas, suffering, and difficulties faced before, during, and after their migration from their homeland. Factors contributing to these mental health challenges and the use of AOD among migrant men include the traumatic journey across the Indian Ocean, adverse conditions in immigration detention centres; language barriers, a lack of information or awareness, insufficient support and social services, such as housing and healthcare, and cultural conflicts.

These combined factors created significant hardships for Iranian forced migrant men, ultimately leading to various mental health issues. In response to these adversities, the migrant men turned to AOD consumption as a coping strategy.

Further, the study results indicated that the Iranian migrant men were subjected to discrimination and racism while at immigration detention facilities, which further aggravated their mental health problems. The outcomes included unfavourable treatment and a lack of basic services and amenities, which negatively affected their overall quality of life. These experiences of discrimination contribute to feelings of marginalisation and can have a profound impact on their mental health, leading to depression, stress, and the rekindling of past traumas from their journey from Iran to Australia.

Moreover, due to the influence of cultural elements and societal norms on masculinity, Iranian migrant men were reluctant to seek help and support. According to Iranian culture, experiencing mental health problems is considered a personal problem and a sign of weakness, especially for men. The reluctance to seek assistance can further amplify the migrants' pre-existing mental health problems. Cultural beliefs surrounding masculinity significantly influence the coping strategies of these men. They may feel compelled to conform to traditional notions of masculinity, which often prioritise emotional stoicism and suppress vulnerability.

Consequently, substance use may be perceived as a means of asserting their masculinity and maintaining the façade of strength in the face of adversity. However, relying on substances as a coping mechanism has detrimental consequences. It not only perpetuates a cycle of addiction and dependency but also obstructs their ability to seek and benefit from professional help.

This study highlighted that a counsellor who shares the same cultural background and language can play a crucial role in encouraging forced Iranian migrant men to open up and express their emotions and experience of depression without fear of judgement, manipulation, or a lack of understanding between counsellors and clients.

The Iranian migrant men expressed comfort in speaking with me and sharing their experiences. As I speak and understand Persian, I was able to grasp the participants' mental health challenges and substance use issues more effectively than when interacting with psychologists who spoke only English. The participants conveyed that they did not encounter difficulties in helping me understand their mental health and substance use concerns. Ultimately, they praised my skills and considered me well-suited for this type of counselling.

In light of this, I contend that effectively addressing and managing the mental health issues faced by Iranian migrant men in Australia necessitates tackling the multifaceted challenges they experience, both during their time in immigration detention facilities and after leaving those centres. Therefore, relevant authorities and migration organisations should prioritise providing migrants with comprehensive support and access to appropriate physical and mental health services.

This study contributes to filling this knowledge gap by providing clarification and more profound insights into the cognitive processes and challenges faced by this population. Such understanding is crucial for the development of targeted interventions and support services that address the specific needs of Iranian forced migrant men in their journey towards recovery and well-being.

In Australia, there is a growing recognition of the importance of addressing social inclusion and providing adequate healthcare services, particularly in the areas of AOD and mental health services. Such attention is especially crucial for migrant individuals who may face additional barriers in accessing healthcare. General practitioners play a vital role in providing healthcare access, and it is beneficial for them to have knowledge and understanding of organisations or services that offer culturally sensitive approaches.

To ensure effective support for individuals from multicultural backgrounds or forced migrants to access essential resources like accommodation and healthcare services, bilingual social workers or case workers are considered valuable assets. These individuals possess the language skills and cultural understanding necessary to provide assistance, support, and guidance to those in need. By having access to such professionals, the process of accessing basic requirements can be made more accessible and tailored to the specific needs of individuals from diverse backgrounds.

This attention should also extend beyond addressing the specific needs and experiences of migrants, including concerns of discrimination, to encompass the provision of appropriate substance abuse treatment and psychological and psychosocial assistance related to the migration process, such as obtaining a visa, learning a new language, and finding employment. Furthermore, it is crucial to recognise the complex interplay between trauma, cultural beliefs, and coping mechanisms in relation to the mental health experiences and consumption of AOD among Iranian forced migrant men. Addressing these issues necessitates a comprehensive approach that takes into account their unique circumstances, provides culturally sensitive support, and promotes alternative coping strategies that encourage healing and resilience.

In addition to the findings from individual interviews, the autoethnographic data drawn from my memory, along with insights from Iranian migrant men, revealed that female counsellors often encounter significant challenges when working with migrants. Indeed, female counsellors may face particular difficulties when dealing with migrant males, especially those struggling with mental health issues and AOD consumption.

Specifically, working with Iranian migrant men can be arduous for female counsellors due to the deep-rooted mistrust and cultural beliefs held by these men. Such mistrust may manifest as resistance or aggression towards female counsellors, thereby hindering the therapeutic process and obstructing access to the support they require. This effect was illustrated by my experiences during my early years, as detailed in the autoethnographic research findings. This phenomenon relates to Iranian cultural norms, which often regard women as inferior to men.

Despite my training and professionalism as a female counsellor, I was not immune to such experiences; I encountered objection and abuse from clients to whom I provided counselling services. However, over time, they began to recognise my importance in addressing their mental health challenges, and I referred them to appropriate agencies where they could access services relevant to their mental health concerns and excessive AOD consumption.

By addressing the language barrier and fostering trust through cultural understanding, I have been able to provide more effective counselling services to Iranian forced migrant men suffering from AOD addiction. This approach has proven beneficial in assisting them to overcome their challenges and work towards a healthier and more fulfilling life. Consequently, the findings of the study underscored the importance of female counsellors in supporting Iranian forced migrant men grappling with AOD and mental health issues linked to my culture and native country.

As a counsellor with a background in Iran, I recognised that the language barrier is crucial when working with Iranian forced migrant men who use AOD. Furthermore, my gender played a significant role in establishing trust and facilitating open communication with these individuals. The results of the FGDs corroborated this conclusion, which became evident during the autoethnographic study phase.

Although I initially encountered challenges when interacting with the Iranian migrant men, they ultimately accepted my services and acknowledged that I possessed superior skills and knowledge to help address their challenges. The fact that I'm a female counsellor contributes to this phenomenon. Research suggests that women can be effective therapists due to their emotional diligence, making it easier for both male and female clients to trust them.

This study highlights the necessity for Iranian women to adopt professional roles when engaging with Iranian forced migrant men, particularly in relation to issues of masculinity and power dynamics during therapeutic sessions. It also emphasises the value of investigating the detrimental effects of cultural gender power on professional women from the same background who work with AOD consumers. This perspective aligns with the feminist theoretical framework, which aims to address the systemic and societal inequalities rooted in culturally defined gender norms.

The feminist theoretical perspective highlights the considerable impact of gender power dynamics and cultural exclusion on Iranian female professionals operating within the AOD and mental health sectors in Australia. I have drawn attention to the emotional consequences these experiences have had on participants, including myself. In my role as a female counsellor, I have occasionally encountered resistance from male immigrant clients, who have asserted that I am

unworthy of addressing or engaging with them. Such experiences may deter Iranian women from entering the counselling profession, thereby restricting the availability of bilingual counsellors in Australia who can provide mental health services to Iranian migrant men, a demographic found to be particularly vulnerable to mental health and AOD issues.

As a result, there is a pressing need to focus more on social inclusion, professional performance, and support for women working in the AOD and mental health sectors in Australia, particularly regarding their interactions with Iranian forced migrant men. This emphasis is essential not only for achieving positive health outcomes in this demographic but also for promoting the inclusion of more women in the counselling profession within the Australian context and thereby enhancing job satisfaction.

Furthermore, the study revealed that participants preferred individual therapeutic sessions, as they appreciated having one-on-one conversations with me once they felt comfortable speaking to a female counsellor. While the benefits of individual therapy were highlighted, group therapy also proved effective, with some participants expressing enjoyment due to the opportunity to share experiences with others who had faced similar challenges. Given these findings, it is important for counsellors and clients to determine which type of therapeutic session to pursue when providing counselling services to migrant men who are at a higher risk of mental health issues and substance use disorders.

Suffice to say, it is crucial to recognise and address the significant challenges faced by Iranian forced migrant men throughout their resettlement process in a new country. These challenges encompass not only their experiences in their home country but also their time spent in detention services and their subsequent integration into the host society. Conducting further

research to better understand the specific difficulties they encounter, as well as their unique needs and appropriate treatment approaches, would be of utmost importance.

To effectively support this population, it is essential to enhance cultural understanding and establish organisations that are specifically tailored to their needs. This includes ensuring a diverse range of healthcare professionals, such as social workers, general practitioners, specialists, counsellors, psychologists, and AOD specialists, who possess a multicultural background and are proficient in different languages. By having professionals who can provide culturally sensitive services and support, we can be assured that Iranian forced migrant men would receive appropriate mental health services and assistance with their drug use problems, which would help them live a healthy life.

Female counsellors can be effective in helping forced migrant men resolve their mental health problems and addiction to consuming AOD due to their ease in building trust and their ability to show understanding and emotional support to their clients. In this study, participants were satisfied that they had a female counsellor who could understand and speak their languages.

By addressing these issues and providing appropriate support, we can contribute to the overall well-being of not only Iranian forced migrant men but also the society as a whole. These efforts can help us create a more inclusive and supportive environment for everyone, regardless of their background.

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Appendices

Appendix 1: Questionnaire

Iranian Research Questionnaire

Yalda Latifi

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My name is Yalda Latifi and I'm PhD student in the Sydney School of Education and Social Work at The University of Sydney. I'm also Bi-lingual clinician (Farsi) at Drug and Alcohol Multicultural Education Center (DAMEC). You are invited to be a participant in a research study aimed at improving the alcohol and drug treatment and mental health services approaches in dealing with culturally and linguistically diverse communities in Australia. We wish to explore and understand the views, suggestions, and experiences of single migrant men from Iran who have experience using Alcohol or other drugs (AOD) and having a mental illness.

All information will be kept and collect confidential, and your name will be anonymous.

Please read the instructions below carefully to answer each question.

1. What is your current intimate relationship status now?

☐Never married ☐Married/ De facto ☐Divorced/ Separated

☐Widowed ☐Girlfriend/Boyfriend ☐Single

2. Do you consider yourself to be?

☐ Heterosexual (straight) ☐ Gay ☐ Bisexual ☐ Other

3. Did you use drugs or alcohol before coming to Australia?

☐ Yes ☐ No

Likert scale questionnaire examples

1. What drugs have you used in the last 5 years?	
Please tick as many from the below list that relate to you	✓
1.1. Alcohol	
1.2. Amphetamines (ICE, Speed)	
1.3. Benzodiazepines (Xanax, Valium)	
1.4. Cannabis/Hashish	
1.5. Cigarettes	
1.6. Cocaine	
1.7. Codeine	
1.8. Fentanyl patches	
1.9. Heroin	
1.10. Hydrocodone (Vicodin®)	
1.11. Morphine (Kadian®, Avinza®)	
1.12. Morphine (Kadian®, Avinza®)	
1.13. Oxycodone (OxyContin®, Percocet®)	
1.14. Street Fentanyl	

1.15.	Street Methadone / Bupe	
1.16.	Other (please state) _____	

For more information, please refer to the below link:

https://adf.org.au/drug-facts/#wheel

2. How concerned are you about each drug from the below list?				
Please select for EACH drug	Very Concerned	Somewhat Concerned	Not concerned	Unsure
2.1. Alcohol				
2.2. Amphetamines (ICE, Speed)				
2.3. Benzodiazepines (Xanax, Valium)				
2.4. Cannabis/Hashish				
2.5. Cigarettes				
2.6. Cocaine				
2.7. Codeine				
2.8. Fentanyl patches				
2.9. Heroin				

2.10. Hydrocodone (Vicodin®)				
2.11. Morphine (Kadian®, Avinza®)				
2.12. Morphine (Kadian®, Avinza®)				
2.13. Oxycodone (OxyContin®, Percocet®)				
2.14. Street Fentanyl				
2.15. Street Methadone / Bupe				
2.16. Other (please state) _____ _____				

For more information, please refer to the below link:

https://adf.org.au/drug-facts/#wheel

3. How concerned are you about the following areas of your life?				
Please tick your responses below for EACH category	Very Concerned	Somewhat Concerned	Not concerned	Unsure
3.1. Employment				
3.2. Financial/money/debts				
3.3. Getting qualifications recognised in Australia that were gained overseas				
3.4. Housing				
3.5. Immigration issues				
3.6. Learning English				
3.7. Other (please state)				

4. How difficult do you find the following aspects of resettling in Australia from the below list?				
Please select for EACH area	Very Difficult	Somewhat Difficult	Not difficult	Unsure
4.1. Adjustment to Australia culture and society				
4.2. Discrimination				

4.3. Isolation and loneliness				
4.4. Loss of culture				
4.5. Loss of homeland				
4.6. Other (please state)				

Focus group questions example

1. What impacts have your migration journey had on your Alcohol and Other Drug consumption?

2. What impacts have your migration journey had on your mental health and wellbeing?

3. What is your experience in seeking psychotherapy and counselling support in Australia?

4. Can you share examples of support or resources you have accessed to help with your wellbeing?

Thank you for your co-operating.

Appendix 2: Participant Information Sheet

HREC Approval No.: 2021/884 1 Version No. 0.3 and 09/03/2022

Participant Information Statement

Research Study:

An evaluation of counselling and psychotherapeutic modalities for migrant Iranian men with co-occurring alcohol and other drug (AOD) issues and mental illness in Australia – A phased mixed methods study

Responsible Researcher:

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1. What is this study about?

You are invited to participate in a research study that explores the relationship between

migration, mental illness, and Alcohol and Other Drugs (AOD) use amongst migrant Iranian men. It will also examine attitudes to AOD use and help-seeking, and beliefs about effectiveness of the particular approaches and treatments available amongst migrant Iranian men.

This Participant Information Sheet and Consent Form tells you about this research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in a focused group discussion or individual interview as part of this project.

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.
The purpose of this study is to help alcohol and drug treatment services improve their approaches with Iranian migrant people who are experiencing mental illness and Alcohol and Other Drugs (AOD) issues in Sydney.

2. Who is running the study?

Mrs. Yalda Latifi is conducting this study as the basis for the degree of PhD with the support of her supervisory panel who are Professor Jioji Ravulo, Dr Sacha Jamieson and Dr Briony Larance (University Of Wollongong). We are located within the Sydney School of Education and Social Work, Faculty of Arts and Social Sciences, The University of Sydney. DAMEC Farsi speaking peer research officer (Ahmad Jadran) will be involved in providing information

and potentially consenting participants into the study.

3. Who can take part in the study?

HREC Approval No.: 2021/884 2 Version No. 0.3 and 09/03/2022

Iranian migrant men aged between 25 – 44 with co-occurring alcohol and other drug (AOD) issues.

4. What will the study involve for me?

If you decide to take part in this study, you will be asked to sign the Participant Consent Form.

You have the option to attend an individual interview, or a focus group discussion led by the Farsi-speaking researcher. Focus groups will involve other study' participants. You will be asked to confirm your consent to taking part in the focus group or individual interview and to have these recorded. Questions in individual and focus groups will be same. In the interviews the researcher will ask for your opinion on topics related to accessing health care and drug use in your community. Participation will take a maximum 1 hour of your time. The researcher will ask you several questions about your drug and mental health treatment experiences. All interviews will be audio-recorded and translated into (spoken words will be written out in text), the written text will be in English.

To consider COVID-19 and NSW Public Health Orders, individual interviews and focus group interviews will be conducted by Zoom and will be audio-recorded.
The individual interviews and focus groups may be held in a private room at Drug and Alcohol Multicultural Education Centre (DAMEC) offices in Blacktown (DAMEC, Level 2, 114-116 Main St, Blacktown, NSW) or by Zoom.

If you take part in an individual interview, we will ask you if you would like a copy of the transcript of your interview. If you say 'Yes', we will confirm your phone number and email details. You can choose to have your transcript sent to your email address or to pick up a copy of your transcript from our Blacktown Office. We will send you a text message to tell you when your transcript is ready.

If you want to make changes to what you said in the interview, you will have two weeks to make any changes to what you said. The researchers will ask if you need help to read the transcript. If we don't make contact with you by email, we try to contact you by phone and email two more times. If you do not respond we will understand that you do not want to make any changes to the information you gave us.

If you do not consent for your interview to be audio recorded, you will still be able to complete the interview via completing the questions with the researcher writing down your answers.

5. Can I withdraw once I've started?

If you wish to withdraw from the interview once it has started, you can do so at any time without having to give a reason. If you do decide to leave, you may ask the researchers to not use any information that has been collected. If at any time after the interview you feel the need to withdraw your information and comments, you may contact the researchers and ask them to do so prior to [insert date], including the date and time your interview was conducted. If you decide not to participate, it will not affect the treatment or services you receive now or HREC Approval No.: 2021/884 3 Version No. 0.3 and 09/03/2022
any treatment or services, including DAMEC services, you receive in the future. Whatever your decision, it will not affect your relationship with support provided to you.

6. Are there any risks or costs?

There is a very small risk that you might become distressed by reflecting on your experiences. Please be aware that a Farsi language counsellor through DAMEC is available to assist you during before or after your participation.
Your contribution to the research interview or focus group is completely voluntary, and you do not need to share anything individually or with the group that you don't want to.
Participation in this study will not cost you anything. Light refreshments will be provided and a gift card of $50 will be offered to cover any time, travel and inconvenience associated with completing data collection.

7. Are there any benefits?

This study aims to improve the way that NSW Alcohol and Drug services in Western Sydney provide treatment to Farsi speaking communities. This study will provide an insight on how to make Alcohol and Drug treatment services more accessible to current and future clients, students, clinicians, and the researchers.

Participants in similar studies commonly report that they are "happy to give back" to the services that they are attending. This is a way that they can help to improve the services available for people in the future.

8. What will happen to information that is collected?

After the interview, audio recording will be transcribed and then deleted. The transcripts will not contain identifying information, and the de-identified data collected in the demographic questionnaire will be out together with other data for writing up and reporting.

Electronic data will be stored securely on the password protected the University of Sydney server and only accessible to PhD student and her supervisors. Consent forms and questionnaires will be securely stored in a locked storage room within the University of Sydney.

All information will be stored for a minimum of 5 years after the completion of the study, after which it will be destroyed. Information you provide as part of this study is confidential. You will not be identified in any publications or presentations.

• **Researcher responsibilities:**

The researchers have a responsibility to provide confidentiality for what is disclosed during the research interviews, focus groups and questionnaires.

Additionally, researchers are required to report any specifying information regarding the involvement in, or knowledge of, any illegal activity if requested by legal services. If you have any concerns throughout the research project, please let the researcher know. Please be aware you are under no obligation to report information to the researchers as participation is entirely voluntary.

9. Will I be told the results of the study?

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You have right to receive feedback about the overall results of this study. The summary of the study' result will be developed and made available to participants wishing to receive the results.

It has been designed a specific part on the consent form. If you are willing to receive the result of the study, tick and provide your email address there. The researcher will be responsible for communicating these results back to you, by emailing the copy of a lay summary of the study result

10. What if I would like further information?

If you want any further information concerning the interview, please do not hesitate to contact Professor Jioji Ravulo Professor of Social Work and Policy Studies, Chair of Social Work and Policy Studies, on jioji.ravulo@sydney.edu.au or phone number: +61 2 9036 4230.

If you have any questions about this research, you can also contact the researcher Yalda Latifi on mlat7185@uni.sydney.edu.au or phone number: +61 2 9036 4230

11. What if I have a complaint or any concerns?

This study has been reviewed by the Human Research Ethics Committee of the University of Sydney [Ethics approval number]. If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the University:

Human Ethics Manager human.ethics@sydney.edu.au

Phone number: +61 2 8627 8176

This information sheet is for you to keep

Appendix 3: Interview Consent

Participant Consent Form

Research Study: An evaluation of counselling and psychotherapeutic modalities for migrant Iranian men with co-occurring alcohol and other drug (AOD) issues and mental illness in Australia – A phased mixed methods study

Professor Jioji Ravulo

Sydney School of Education and Social Work

Faculty of Arts and Social Sciences

Level 7, Rm 727a Education Building A35

The University of Sydney | NSW | 2006

Phone: +61 2 9036 4230 | Email: jioji.ravulo@sydney.edu.au

Ms. Yalda Latifi (PHD Student of Social Science)

Email: mlat7185@uni.sydney.edu.au

Participant Name _____

I agree to take part in this research study. In giving my consent, I confirm that:

- The details of my involvement have been explained to me, and I have been provided with a written Participant Information Statement to keep.

- I understand the purpose of the study is to investigate counselling and psychotherapeutic modalities for migrant Iranian men with co-occurring alcohol and other drug (AOD) issues and mental illness in Australia.

- I acknowledge that the risks and benefits of participating in this study have been explained to me to my satisfaction. I am aware that I may not necessarily benefit personally from participating in this project.

- I acknowledge that all my questions answered are to my satisfaction and understand that I can contact the research team if I have any additional questions.

- I understand that in this study I will be required to the individual interview or a focus group interview as my chosen preference of participation.

- I understand that my participation in the individual interview or focus group interview both will be audio taped. I understand that this is a requirement of participation and that it is only for the purpose of recording the content of discussions and identifying any recurrent themes.
- I understand that the individual interview or a focus group interview will be conducted on Zoom if local health advises, and rules prevent in person participation.
- I understand that being in this study is completely voluntary.
- I understand that I am free to withdraw from this study at any time and that I can choose to withdraw any information I have already provided (unless the data has already been de-identified or published).
- I am assured that my decision to participate will not have any impact on my relationship with the research team, The University of Sydney, or Drug and Alcohol Multicultural Education Centre (DAMEC).
- I understand that my decision whether to participate in this project will not affect the care provided to myself by health care services including DAMEC or with The University of Sydney in the present or future.
- I understand that The University of Sydney research team will have access to the information that I provide. I understand that all personal information that I provide, is completely confidential and will not be passed on to any other person, except as required by law.

- I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

    - I confirm the following:

Preferred Interview Method Individual ☐ Focus Group ☐

I consent to audio recordings Yes ☐ No ☐

I would like to review my interview transcripts Yes ☐ No ☐

I would like feedback on the overall results of this study Yes ☐ No ☐

If you answered **yes**, please provide your preferred contact details (email/telephone/postal address):

_____

_____

_____

- I understand that after I sign and return this consent form it will be retained by the researcher, and that I may request a copy at any time.
- Complaints may be directed to the Sydney Human Ethics Officer on +61 2 8627 8176 or email jioji.ravulo@sydney.edu.au and quote HREC reference number [ ].

CONSENT BY PARTICIPANT:

Participant Name _____

Signature _____

Date _____

DECLARATION BY RESEARCHER:

The participant has received written information about the research project and has had the opportunity to have any questions addressed.

Researcher Name _____

Signature _____

Date _____

Appendix 4: Safety Protocol

The Safety Protocol

1. The researcher will be in constant contact with the supervisors before conducting any interview and inform them of the time and place of the interview.
2. The researcher will receive the necessary support, including emergency services contact, if necessary, before proceeding with the interview.
3. Obtaining the necessary training on conducting interviews and managing stress before conducting interviews with the participants.
4. Conducting interviews during daylight hours and in places close to the presence of other people (staying away from remote and isolated places).
5. Seeking a professional practitioner to be present at the place of the interview (in the next room) to intervene, if necessary, in addition to the researcher will offer to end the interview if necessary.
6. The researcher is committed to managing emotion and restraint, speaking in a respectful manner throughout the interview, and training to calm the situation.
7. Full debrief with study team will occur after any incident and that safety protocol may be reviewed and amended as part of this process.

Assessing risk of violence

A potentially violent person should never be interviewed alone; at least one colleague should be present. In practice, this means a second person is either located within the interview room with the participant and interviewer, outside the room but next to the door which is to be left ajar or

accompanying the interviewer to the off-site location. There should always be clear access to an exit so interviewers can leave the room quickly if need be. In the event of an episode of physical or verbal aggression or violence, the injured person(s) needs to be comprehensively supported (both physically and psychologically) at the time of the event (i.e., transported to Accident and Emergency or transported to wherever they are staying). The incident should be immediately reported to the project supervisor, police or other emergency service as required. An online incident form must be completed on the USYD website as soon as practicable. Debriefing and support counselling should be offered within 48 hours of an episode of violence (http://www.counselling.unsw.edu.au/). In addition, the circumstances of any verbally or physically violent episode should be fully documented and used to prevent similar situations. Depending on the study, incidents should be recorded on project materials. This is particularly relevant for longitudinal studies, where the information can be used to manage future interviews with participants. In addition, Interviewer Safety Manual any potential risk alerts should be fully documented so that other staff that may have contact with the participant can be alerted to potential issues or safety concerns.

Managing risk

Drug and Alcohol Multicultural Education Centre (DAMEC) is an organisation to improve and access to health care and to health and wellbeing for culturally and linguistically diverse populations (CaLD) who may be experiencing co-occurring AOD and mental health related issues.

- DAMEC has consented to PhD student conducting interviews on their premises at that time and are aware of the study and the eligibility criteria.
- DAMEC staff will be aware that an interview is being conducted and know approximately how long the interview will take.

- PhD student is familiar with the agency and have had an induction into workplace health & safety emergency procedures and safety arrangements for the interviews.
- PhD student is familiar with agency protocols regarding client interviews and these protocols are followed or alternatives arranged with the agency.
- The interview takes place in a room that is well within the hearing range of agency staff.
- The interview is conducted in a well-lit and relatively private room, or at least a room where DAMEC staff can supervise.
- PhD student will not show participants that they have any more money than is necessary to pay that participant – which is in the form of a gift card. DAMEC peer worker who is not interviewing takes charge of the gift card; participants can only receive their gift card from this person at the completion of the interview.

Minimising risk of violence

The participants demographic of this research is not involved interviewing with violent people, however below protocols are considered to mitigate this low risk.

- Interviewing in a medium or large sized room to ensure participants feel comfortable.
- PhD student will be seated close to the exit to execute safety protocol if required.
- Not sitting or standing within-arm's-length of the participants.
- Removing any throwable objects from the interview desk.
- PhD student will be remaining aware of her interview style - ensure her posture is not confrontational, keep her tone of voice ushered and respectful.
- PhD student will terminate the interview if she feels anxious about possible assault, or that she has lost control of the interview.

- If the situation escalates, and PhD student feel comfortable doing so, ask the participant to stop or she will escalate this to office manager of DAMEC. If repeated requests to calm down have little effect, advise the participant that the interview is over, pay them for their time via a gift card, and take herself to a safe place. She will call the police if necessary.

The procedure to be followed by individual projects should be decided prior to commencing interviewing. It is crucial that the project supervisor is informed of this step if it is taken, and the decision to call the police be made in conjunction with the supervisor, if possible.

- If necessary, PhD student will activate personal safety alarm.
- PhD student will be trained in de-escalation.

Section F question number 361 of ethics application discussed minimising risk of violence in more detailed.

Assessing intoxication

All participants will be assessed for their level of intoxication prior to the commencement of the interview by PhD student. Intoxication is not always obvious, though a quick and discreet assessment can be used to inform your PhD student decisions as to whether a participant should be interviewed. Physical presentation is a key indicator of intoxication, and the following physical signs should be assessed:

- Gait – stooping, rigid
- Pupils – pinned or dilated
- Speech – slurred, slow, fast or erratic
- Smell – alcohol on the breath
- Clothes – dirty and dishevelled

- Hair and skin – dirty or untidy

A brief psychological assessment can also be carried out. Interviewers will assess the participants':

- Level of consciousness
- Orientation
- Memory
- Judgment
- Mood – aggressive, forceful, intimidating
- Comprehension
- Perception – hallucinations, paranoia

These points can be tested by going over inclusion criteria with the participant and engaging in conversation long enough to assess the characteristics listed above. Their recognition of the time of day and location can also be used to assess their level of intoxication. If the participant is too intoxicated; the interview can be concluded. In these circumstances, PhD student respectfully will explain that the interview cannot be completed at this time, but that they are keen to interview them and are happy to reschedule the interview for another time. If the PhD student feels increasing aggression may place them at risk, it might be necessary to end the interview sensitively, thank them for their time and reimburse the participant for their travel expenses via a gift card.

Researcher Name Yalda Latifi

Signature _____

Date _____

Supervisor Name	Professor Jioji Ravulo
Signature	
Date	

Appendix 5: Poster

Appendix 6: Coding and theme generation

Extracted texts	Codes	Context	Themes
I had been using it when I was in Iran [Saeed]	History of drug use at home country and AOD consumption	Pre-migration	History of drug use and consumption of AOD
I had been using alcohol before moving to Australia [Saman]			
Terrible and horrible memories from the boat and those terrible memories from the Indian Ocean [Mehdi]	Terrible migration journey	Migration	Terrible migration journey from Iran to Australia and mental health
Even after leaving the detention facility, I was also disturbed by endless memories about the fears I experienced while at the detention facility [Ali]	Mental disturbance and fears experienced at detention facility	Migration	Detention and impact on mental health

Uncertainty is a huge pain [Majid]	Uncertainty		
…that feeling of loneliness and severe stress which we had during that time that we were in the detention centre [Mehdi]	Stress at detention facility		
Loneliness and severe stress which we had during that time that we were in the detention centre [Mehdi]		Migration	Migration and loneliness
And this loneliness, I've repeated that multiple times, has affected me [Majid]	Loneliness		
I've been hard hit by feelings such as loneliness [Abbas]			

That void of loneliness pushed me into a relationship with a woman 16 years older than me [Saman]			
Loneliness is bothering me too much [Shahid]			
I slept in the streets. I was lonely and friendless [Iman]			
All because of fear, loneliness, and things which I couldn't realize at first [Amir]			
Mental and moral problems resulting from immigration [Hossein]	Immigration and mental and moral problems	Migration	Migration and mental health problems
Immigration has imposed some psychological issues [Hossein]	Immigration and psychological issues		

I was treated differently from other immigrants who arrived by air [Mohsen]	Being treatment differently from others	Migration	Racism and discrimination
Many got out and did nothing [Amir]	Inability to access assistance and needed medical help	Post-migration	Unable to access assistance needed
I requested mental and physical assistance multiple times regarding the challenging issues I am facing but have not received any response [Azad]			
I visited a psychologist many times without getting the assistance I needed [Saeed]			
When I moved to Australia, I got addicted [Iman]	Being addicted to AOD	Post-migration	Relationship between alcohol consumption

Because of using alcohol my depression got worse [Abbas]	Alcohol consumption and depression		and mental health problems
Alcohol has made me miserable, has made me depressed [Abbas]			
There were psychological problems which pushed me to consume alcohol [Shahid]	Psychological problems and alcohol consumption	Post-migration	
I arrived here amidst COVID-19 pandemic. Things were not easy for me since it was not easy to find employment [Majid]	Difficulty finding job	Post-migration	Barriers to building new life
I still have obstacles in my relationships and my job [Mehrdad]	Problem with job and relationships		
Our English was not good enough [Pasha]	Poor communication and language barrier		

Visa issues are one of these roots [Javad]	Visa issues and mental health		
We didn't have a work permit [Hossein]	Unemployment		
They paid a salary which we couldn't live on [Hossein]	Unreliable salary and poverty		
We searched for a house for almost 3 months, all by walking [Hossein]	Problem getting house and transport		
I struggled a lot to share with the psychiatrist [Hossein]	Struggling to share with psychiatrist	Post-migration	Cultural barriers and help seeking for counselling services
Type of English the psychiatrist spoke is not the type of English I was used to back at my home country [Hossein]	Language barrier and communication challenges		
Our culture back at home does not	Cultural differences		

acknowledge mental health issues as a treatable disease [Shahid]			
…couldn't make connections with foreigners at all because my English was not good and they didn't hold any language classes or anything [Amir]	Unable to connect with locals	Post-migration	Cultural stressors and mental health
…what if I can't make a good relationship [Mehrdad]	Unable to make good relationships		

Autoethnographic analysis

Extracted texts	**codes**	**Themes**
As a woman counsellor I don't trust you [Mohammad]	Trust	Challenges of female counsellors
I don't trust you because you are a woman [Vahid]		

I'm educated like you, but you are employed in Australia [Ali]	Comparing	
I am a man [Ali]	Threatening behaviour	
Obey whatever I tell you [Farhad]		
I know where your husband is working [Kourosh]		
remember I'm a man [Kourosh]		
"What a beautiful counsellor! If I had known my counsellor was a woman, I would not have refused to come for a counselling session [Azad]	Male patients' inappropriate behaviour	
I thought I must behave harshly because you are a woman [Behrouz]		
Are you married? Why did I not see you before you got married? [Javad]		
I was going mad because of the repayment debt [Abbas]	The need for assistance with other compounding problems	Need for assistance with other needs

They found an Iranian psychologist for me [Mehdi]	Psychiatrist assistance	
Clearly understood my problems [Mehdi]	Understanding male clients	Person-centred care and cultural-centred assistance
I felt I needed to talk to someone [Hassan]		
Thank God I met the NA program here [Sajjad]		
The NA program helped me [Abbas]		
I felt you listened [Hamed]		
I felt you understood me [Hamed]		
Showed understanding to my issues [Hossein]		
Communicating in Persian is very important [Amir]		
Connected us to a good psychologist [Abbas]	Counsellors' role in connecting male patclientients to needed support services	Connecting clients to needed support and assistance
Determination to provide support [Hossein]		
I got a lot of help from here [Mohammad]		

This helped me alleviate the anxiety and stress [Hossein]		
Connect with an employment agency [Hossein]		
Mentor for self-esteem, how to confront our fears and how to face our emotions [Sajjad]	Helping migrants overcome fears and gain self-esteem	Helpful therapeutic processes
DAMEC had mental health and couple therapy groups and services [Sajjad]	Group therapy services for mental health issues	
Relieve I got by participating in group programmes [Amir]	Group therapies and relief	
Women's words are something I can connect easily with [Hamad]	Easy to connect with female counsellors	
Gradually it seems the self-confidence came back and now I'm alright [Sina]		
The empathy feeling which you gave me, frankly you became like a sister to me [Behrouz]	Empathy	

I was feeling like I was meeting my sister [Behrouz]	Trust for female counsellors	The importance of gender in counselling
I have the experience that I can trust my mum very easily, I think a woman is like this [Mohsen]		
You have the power which ten men don't [Ali]	Power of female counsellors	
Emotion-wise women are more effective [Abbas]	Effective of women counsellors in eliciting emotions	
I prefer an opposite sex psychologist [Abbas]	Female counsellor preferred by migrant men	
I feel comfortable in front of you [Abbas]	Comfortable getting counselling services from female counsellor	
Women have a great influence on men. A woman is better [Shaharam]	Female counsellor's influence	