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Views on Seeking Mental Health Services in the Somali Community

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Views on Seeking Mental Health Services in the Somali Community

By

Hamdi H. Adan, BSW

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
University of St. Thomas and St. Catherine University
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members
Karen Carlson, Ph.D., (Chair)
David Schuchman, MSW, LICSW
Faizo Mohamed, BSW, LSW

The Clinical Research Project is a graduation requirement for MSW students at the University of St. Thomas/St. Catherine University in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social work research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

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By

Hamdi H. Adan

Research Committee:

Chair: Karen Carlson, Ph.D.

Members: David Schuchman, MSW; Faizo Mohamed, BSW

Abstract

There is a need for culturally sensitive and suitable health care in the United States since there is a rising population of immigrants and refugees that reside in this country. The purpose of this research is to examine the views of mental illness among Somali individuals that live in the United States. A quantitative design was used for the collection of the data by using survey. Thirty six participants completed the written survey. Data was analyzed using a descriptive and inferential statistics to investigate the relationship between the participant's level of education, the participants' length of stay in the United States, and their views on mental illness. The results showed that there was some significant relationship between the variables for those who participated in the research.

Acknowledgements

I would like to express my sincere appreciation to Karen Carlson Phd, Chair of my Clinical Research Committee, for her guidance and support on this project. I would also like to express my gratitude to my research committee members, David Schuchman and Faizo Mohamed, for their guidance and recommendations in the development of my research. I truly appreciate and value the time they have put in reading and revising my paper as well as the supportive feedback they provided me with.

I would like to thank my family and friends for the continuous love and support while continuing my education. Special thanks to my dear mother who has been nothing but supportive who has been cheering me on in every milestone I have accomplished in my life. She truly is an inspirational woman whom I consider my role model.

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Introduction

Somali people moved to America in the hopes of a new beginning. Minnesota is considered to have the largest number of Somali residents in the country according to 2010 American Community Survey data (Somalis in Minnesota, n.d.). "The survey estimates the national population at 85,700 and the Minnesota population at more than 32,000, with the majority of Somalis living in Minneapolis and St. Paul" (Somalis in Minnesota, n.d). Somalis experience life in Minnesota in a completely different way than experiences they might have had in their home country, as everything would be new to them. Many Somalis come to Minnesota, as well as other states, in the hopes of gaining opportunities that they might not have had in their home country although they are aware of the challenges they will face along the way. In the midst of this process, Somalis must learn a whole new culture and customs, as well as new language.

Somalia's mental health treatment structure were seriously disrupted after the civil war erupted in Somalia in 1990 (Abdi, 2013). "To date, government in Somalia does not have an official mental health plan of action to combat mental illness, rebuild facilities, and grant funding to support programs" (Abdi, 2013). A lack of resources in Somalia and Somalis not being aware of how to best assist those with mental illness resulted to chaining those with mental illness to beds or rocks (Abdi, 2013). There are a lot of Somalis who migrate to America who might have mental illnesses that they did not get treatment for in their home country. There are times due to language barrier in America that a Somali person's mental illness goes unnoticed, thus remaining untreated. Somalis are either aware of their mental illness and seek out treatment or they might be in

denial and might not want treatment or seek out treatment. Additionally, they might not know that what they are experiencing is something that can be changed.

Amongst Somalis there is a notion that there is no such thing as “mental illness” and that you are either crazy or you are not. Some Somalis are concerned with the label that comes with the illness and would rather say that they are fine and are in no need of help. Some Somalis are okay with some illnesses as long as it is an illness they believe is not permanent and could be fixed. There are some barriers faced by the Somali community, which restricts them from seeking treatment for their illnesses. Lack of knowledge or fear of the unknown creates this barrier for some Somali people who could benefit from receiving mental health services. This research project answers the following questions: What is the correlation between duration of staying in the United States and attitudes toward seeking mental health services? What is the correlation between the level of education and attitudes toward seeking mental health services?

Literature Review

History of Somalia

Somalia is located in eastern African region known as the Horn of Africa and its neighboring countries are Djibouti, Ethiopia, and Kenya. To the north of Somalia is the Gulf of Aden and to the east of Somalia is the Indian Ocean. Mogadishu is the capital of Somalia and also the largest city. Somalia covers about an area of 638,000 square kilometers. Although there is a discussion among scholars on the origins of Somali people and their coming into present-day Somalia; references to Somalia can be found several hundred years before the early 15th century (Putnam & Noor, 1993). Somalia got its independence from Britain in 1960 and at that time a government was formed.

Citizens of Somalia relished a great level of political involvement for the next nine years after gaining independence (Putnam & Noor, 1993). Somalia was a growing country in the 60's, 70's, and 80's era; more people were moving to the capital city, Mogadishu. Close to the end of the 1960's, while politicians were occupied with difficulties of progression, Major General Siyaad Barre's army took over and shortly after General Barre was named President (Putnam & Noor, 1993). "The socialist regime sought to improve the status of minorities and women, and after introducing a Somali writing system in 1972, launched countrywide literacy campaign" (Putnam & Noor, 1993, p.8). There was a huge movement of teaching the language to everyone so students were sent all over to the rural areas to teach the language.

The country broke into a civil war in 1990 based on clan divisions; people fled their homes to other cities as well as other countries. Siyaad Barre's military regime broke down at the end of January in 1991 and everyone went to defend their own tribe (Putnam & Noor, 1993). Education decreased significantly due to political upheaval and the civil war. The country fell into anarchy, with increased fighting between rival clans, as well as armed bandits and warlords. The civil war between the various clans has continued on and off for more than twenty years. In addition to the civil war, the Somali people suffered drought, food shortages, and famine and might have lost family members or suffered horrific events during the war. "In August 1992, an estimated one fourth of Somalia's population, about 1.5 million people, was in danger of starvation" (Putnam & Noor, 1993, p.12). Currently, there is an official government and Somalia is at the beginning of a process to rebuild the country.

The effects of the war that has been raging in Somalia for more than twenty years goes beyond destruction of infrastructure and economy. The collapse of an entire country lead to consequences that are enormous. One of the main effects it had is the impact on the mental health within the Somali people and the even harder concept to grasp is the lack of support, as well as understanding of the experiences an individual with a mental illness is going through. When an individual has a mental illness the right resources are not readily available, since people will try to solve the issue in other ways instead of going to a professional. Other obstacles that arise are the lack of understanding or education of what the individual with a mental illness is dealing with. Some people feel that there is shame with getting help due to being stigmatized or fear of others thinking that something might be wrong with this individual. This comes from a history of lack of availability of resources for individuals with mental health disorders in Somalia. It also has to do with a different understanding of what we call mental illness. This leads to the individuals being neglected and young children chasing the person with mental health around and even throwing things at them. Other adults that are around may attempt to stop such behavior but this shows the lack of understanding of how individuals with mental should be treated which increases the negative stigma.

Family Dynamics

The societal composition amongst Somalis is grounded on family and clan groups. Affiliation of clan stems from the father's ancestry. Somalis often display a firm allegiance to their immediate family, clans, and friends. Usually Somali families live in a multi-generation family unit. Somali names have three parts. The first name is the given name by the parents and at times first name could be a grandparent's name. The second

name is inherited from the child's father and the third name is inherited from the child's paternal grandfather. Therefore, siblings of both genders share the same second and third name. The father is the head of the family under the Islamic law and it is the father's obligation to support the family. Traditionally the father provides for the family and the mother takes care of the children. However, after the civil war many families were separated due to migration and many families lost loved ones in the war. Therefore, there are many single mothers who took on the role of being the provider due to their husband's dying in the war or being separated from their husbands due to the war or other causes. Older adults in the Somali community are highly respected and are sought out for advice when problems arise and are also seen as mediators for conflict.

Somali Cultural Beliefs and Religion

The majority of Somalis are Muslim and follow Islamic practices. Among Somali individuals there is a belief that one is either crazy (waali) or not crazy in regards to their perceptions of mental health (Schuchman & McDonald, 2004). Somalis believe that illness is caused either by Allah (God), evil spirits (jin) or evil eye. The evil eye is misfortune or illness caused by a person wishing harm on another. Most Somalis are familiar with traditional Somali healing practices. There are several types of traditional healers in Somali culture: spiritual healers and traditional healers. Spiritual healers use religious rituals for healing. The traditional healers are wise men or women who practice what has been taught to them from past generations. Healing techniques include applying a heated stick from certain trees to the skin. This is done for tuberculosis, hepatitis or diarrhea to stimulate the immune system. Herbs and prayer also are used for healing.

If a Somali person demonstrates indicators of mental illness, their families are the ones who provide the initial care; however, they would also seek out assistance from religious leaders and traditional healers instead of seeking medical help. “Because Muslim immigrants are encouraged to deal with their mental health issues internally (i.e., in their community and extended families), naturally, there is a mistrust toward mental health counselors in general (Ali, Liu, & Humedian, 2004; Al-Krenawi& Graham, 2000 as cited by Amri and Bemak, 2013, p.51). They believe that they would be able to be cured from the mental illness if a healer recites the Quran on them. While some Somalis may believe that the civil war had occurred because they were being punished for the wrongdoings that they have done, others believe that what happened was fate (Schuchman & McDonald, 2004). “When the initial survivor's guilt has dissipated, many trauma survivors experience a “nagging remorse that seems to grow stronger, shifting the focus away from the immediacy of the intrusive imagery to a repetitive anguish about the role of one's own actions and choices in the tragedy” (Schuchman & McDonald, 2004, p.68). In the Islamic faith it is forbidden for an individual to commit suicide. Schuchman and McDonald (2004) noted that although belief in religion could be a reason to stay away from committing this act, it is also may inhibit someone from requesting help if they are considering suicide. An important issue here is how people understand or explain what we call “mental illness.” If, for example, someone believes that their problems stem from God, they will go to a religious healer to solve the problem. If they believe it’s a curse from another person, they might go to a traditional healer. A person’s explanatory model influences if and how they seek relief.

Although Somali individuals believe that ailments and health conditions come from Allah (God), they also believe that forgiveness will come from the suffering that they face. They believe that trials and tribulations are a form of purification for self. Those who are believers and practice the faith understand the punishment of Allah is not out of anger or wrath; the punishment of Allah is a means of cleansing you of your sins. Muslims believe that hardships are to protect them from their own sins and that Allah sends them hardship to direct them. Allah guarantees after every hardship there is ease and He does not take anything from His creation except that he replaces it with something better either in this World or the Afterlife. In the Somali culture, death and dying are commonly accepted as a natural part of life. The majority of Somalis who are of Islamic faith believe that death is a preordained destiny and recognize it as inexorable.

How Mental Health is Expressed Amongst Somalis

Carroll (2004) conducted her research to gain knowledge from seventeen Somali refugees in Rochester, New York to further comprehend how mental illness is articulated and treated in this population. Carroll (2004) points out in her study that most of the Somali participants did not believe that mental illness had emerged in their society before the war in Somalia. "Most (14 of 17 interviewed) participants stated that mental health problems were a significantly more widespread, common problem for Somalis now than they had been before the civil war began in 1991" (Carroll, 2004, p.121). Guerin, Guerin, Diiriye, and Yates' (2004) research focused on helping practitioners to understand what Somalis views are on mental health and how to enhance providing aid to the older population since it is essential for them to receive mental health services for various purposes. Carroll (2004) found that what Somalis believed to have contributed to mental

illness was ‘loss’ and ‘suffering’ because of the destruction caused by the war in Somalia. Guerin et al. (2004) emphasizes that most Somalis do not understand what they will gain from sharing their difficulties with an outsider who is not from their kin or community. “Three major types of mental problems were identified that were associated with specific behaviors and treatment strategies: *murug* (sadness or suffering), *gini* (craziness due to spirit possession), and *waali* (craziness due to severe trauma) (Carroll, 2004, p.119). “Among the most frequent somatic symptoms described by Somalis when seeking help in a mental health clinic are: physical complaints including body pain, headaches, sleep problems, fatigue; decreased appetite and weight loss or gain; low energy” (Schuchman &McDonald, 2004 p.68). According to Schuchman and McDonald (2004), Somalis also reported problems related to flashbacks of events, bad dreams and an intensification of fear frighten response (Schuchman &McDonald, 2004)

Carroll’s (2004) study showed that there was a disagreement about whether it would be helpful to consult a physician. Five participants believed it would be helpful, six believed it would not be helpful and the remaining six stated “they would only consult a doctor for physical symptoms caused by *murug*” (Carroll, 2004, p.122). Carroll (2004) confirms that there was no separation in ‘gender, education level and duration of U.S residence in regards to distinctions of viewpoints within the participants (p.122). There were only six out of the seventeen participants who were aware “that medications were available for sadness or emotional symptoms” (Carroll, 2004, p.122). The study showed that, “most participants attributed murug and waali largely to traumatic refugee experiences, the larger socio-political devastation of civil war and famine, and, in some cases, post migration stressors” (Carroll, 2004, p.124). In the study, it was noted that

waali and *gini* was considered more 'stigmatizing' to the Somali participants than *murug*; however, approaches for healing involved "family community and often prayer" (Carroll, 2004, p.124). "For many Somali, traumatic experiences are readily accepted (but not always) as 'God's will' whereas traumatic experiences in a western perspective are assumed to require therapeutic treatment" (Guerin, Guerin, Diiriye, & Yates, 2004, p.62). Guerin et al. (2004) findings were similar to Carroll (2004) that Somalis would seek out community members, the teachings of the Koran as well as other additional methods in coping with their mental health concerns. Schuchman and McDonald (2004) noted Somalis physical symptoms that are present are understood as applicable to an emotional or psychological event. "Psychological problems are often expressed somatically as headaches, chest pain, and forgetfulness; sleep problems, nightmares and sweating" (Schuchman & McDonald, 2004, p.67).

Palmer (2007) found that many of the participants were disinclined to disclose having any problems with their mental health due to the fear of being cast-off and not being able to interact with the community. In study, one of the participants states, "People in the community do not want to be with you if you are mad" (Palmer, 2007, p. 184). Palmer (2007) noted that the Somali people could be facing obstacles to having entry to "community and mental health services" due to the view of mental illness in their culture therefore this inhibits them from working together with mental health practitioners (p.187). Palmer (2007) found that most of the participants felt like they were not able to uphold a tie with their community, not able to gain access of any sort, and felt detached due to issues of trust and stigma. "As a result, they were caught between

perceptions and inequality of two societies; they could not identify with the western mental health system" (Palmer, 2007, p.188).

Stigmatization of Mental Health

The study conducted by Golberstein, Eisenberg, and Gollust (2008) explores the negative connotation associated with mental health and the effects it has on an individual's ability to seek out mental health services. The study took mainly graduate and undergraduate students and assessed the state of their mental health as well as their perception of the public stigma associated with mental health. The results indicated that age, gender, race, and socioeconomic status were all factors in the perceived levels of stigma that individuals experienced. "Although this study is limited in its ability to make causal inferences, the results suggest that among university students, perceived stigma toward mental health treatment may not be as strong a barrier to using mental health services as the current policy discourse assumes" (Golberstein, Eisenberg, & Gollust, 2008, p.397).

Wahl's (1999) study, unlike Golberstein et al. (2008), shows the deeper effects stigma has on people and how it affects their daily lives. It takes a closer look at their thoughts, feelings, and personal experiences with discrimination and the stigma that comes with mental health. Wahl (1999) states:

> The majority of respondents tended to try to conceal their disorders and worried a great deal that others would find out about their psychiatric status and treat them unfavorably. They reported discouragement, hurt, anger, and lowered self-esteem as a result of their experiences, and they urged public education as a means for reducing stigma (p.467).

In addition to age, gender, race, and socioeconomic status, Wah's study also took into consideration educational level, employment status, and current living situation. It also took a closer look at what individuals were diagnosed with and the number of times they'd been hospitalized. Respondents reported living with a constant fear that the status of their mental illness would be exposed and thus be treated differently or unfairly. Many of them worried that people would treat them harshly if their mental illness was revealed. "More than one quarter of the respondents (27%) found themselves often or very often being advised to lower their expectations in life; for example, they were counseled to reconcile themselves to jobs well below their level of education, intellect, and training" (Wahl, 1999, p.470).

Corrigan's (2000) study is a bit more comparable to the study Wahl (1999) conducted. Corrigan's (2000) study focuses on stigma, the signals that lead to it and the stereotypes that give meaning to the signals. He then goes on to talk about the discrimination that occurs as a result of these stereotypes. Corrigan's (2000) study focused on how to change the negative connotation associated with mental health and narrowed it down to three: protest, education and contact. "Protest is a reactive strategy: it diminishes negative attitudes about mental illness, but fails to promote positive attitudes that are supported by the facts. Education provides information so that the public can make more informed decisions about mental illness" (Corrigan, 2000, p.60). Being more informed and participating in programs that are in place to educate the public about mental illness will lead to people having a more positive attitude towards individuals with mental illnesses.

Mental Health Issues among Somalis in America

Kroll, Yusuf, and Fujiwara (2011) studied Somali patients over the age of 18 who were evaluated in the Mental Health Department of the Community University Health Care Center (CUHCC) from 2001 to 2009 to explore key forms of psychiatric disorders and compare results with non-Somali patients seen at the same clinic from 2007-2009. Two key discoveries that developed from the Kroll, et al. study was the elevated level of psychosis in young Somali men seen in the clinic which was unanticipated due to not being illustrated to this magnitude in other literature that was done on Somali refugees and an anticipated configuration of co-morbid depressive and PTSD symptoms among women and older men patients which relate to other studies of war refugee populations. This study concluded that "War trauma experienced in childhood, early malnutrition from famines, head trauma, and excess Khat use in male adolescents provide partial explanations for the large number of young psychotic Somali men seen in the clinic from 2001 to 2009" (Kroll, Yusuf, & Fujiwara, 2011, p.481).

Conceptual Framework

As social workers, it is vital to use theory to help to support and guide in the method of understanding different questions and concerns as they arise when working with clients of different populations. Also, it is important when conducting clinical research to use theory to pave the way in supporting to clarify and examine essential issues and questions that needs to be countered or spoken about. This researcher used acculturation theory as the conceptual framework to approach the clinical research question that was stated in the introduction portion of the research.

Acculturation

One of the purposes of this study is to explore whether a Somali person's level of acculturation relates to attitudes towards seeking mental health services. "Acculturation is the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005, p.698). Berry (2005) noted that a significant piece of acculturation is the changeability that occurs in regards to in large group and individual distinctions in which people go about their acculturation strategies and to what level they attain suitable alterations. The strategies of ethnocultural groups are integration, assimilation, separation and marginalization. "Acculturation is a process of cultural and psychological changes that involve various forms of mutual accommodation, leading to some long-term psychological and sociocultural adaptions between both groups" (Berry, 2005, p.699).

Acculturation occurs when groups of people from different cultures come together and adopt the behavior patterns surrounding a particular culture that differs from their own (Berry, 2005). When intercultural contact occurs between these groups of people, conflict is a prospective possibility. In addition to conflict, this article focuses on negotiation and mediation across cultures. The emphasis is put on how individuals from these cultures can relate to one another and coexist (Berry, 2005). This is achieved through negotiation and comprising so that conflict is avoided.

Methodology

Research Design

This study is a quantitative cross-sectional design. Quantitative data was composed to determine the variable that shaped views on seeking out mental health services in the Somali people residing in the U.S. The informed consent form (see Appendix A) was reviewed with participants before survey was provided. The survey was handed to the participants to fill out. The research questions explored to see if there is a correlation between education levels, and duration of being in the U.S among Somali individuals and their views on seeking out mental health services.

Protection of Human Subjects

Measures were taken to protect participants when conducting survey. The study was reviewed and approved by the Institutional Review Board (IRB) at the University of St Thomas before conducting the survey to ensure the protection of participants. Before providing the survey, researcher provided consent forms (see Appendix A) that were pre-approved by the IRB to the participants. The consent form discussed measures taken to assure confidentiality and defined how the data was kept confidential. The researcher reviewed the consent form with participants before taking the survey and gave them the opportunity to address any questions about study and measures. The information included in the consent form was the intent of study, risks and benefits of participating in study, confidentiality, and the voluntary nature of study. Also, the researcher's contact information and supervisory chair information for the research project was included in the consent form in case any questions arise for the participants. Participants were also informed that they had the right to stop taking the survey at any time. The survey did not

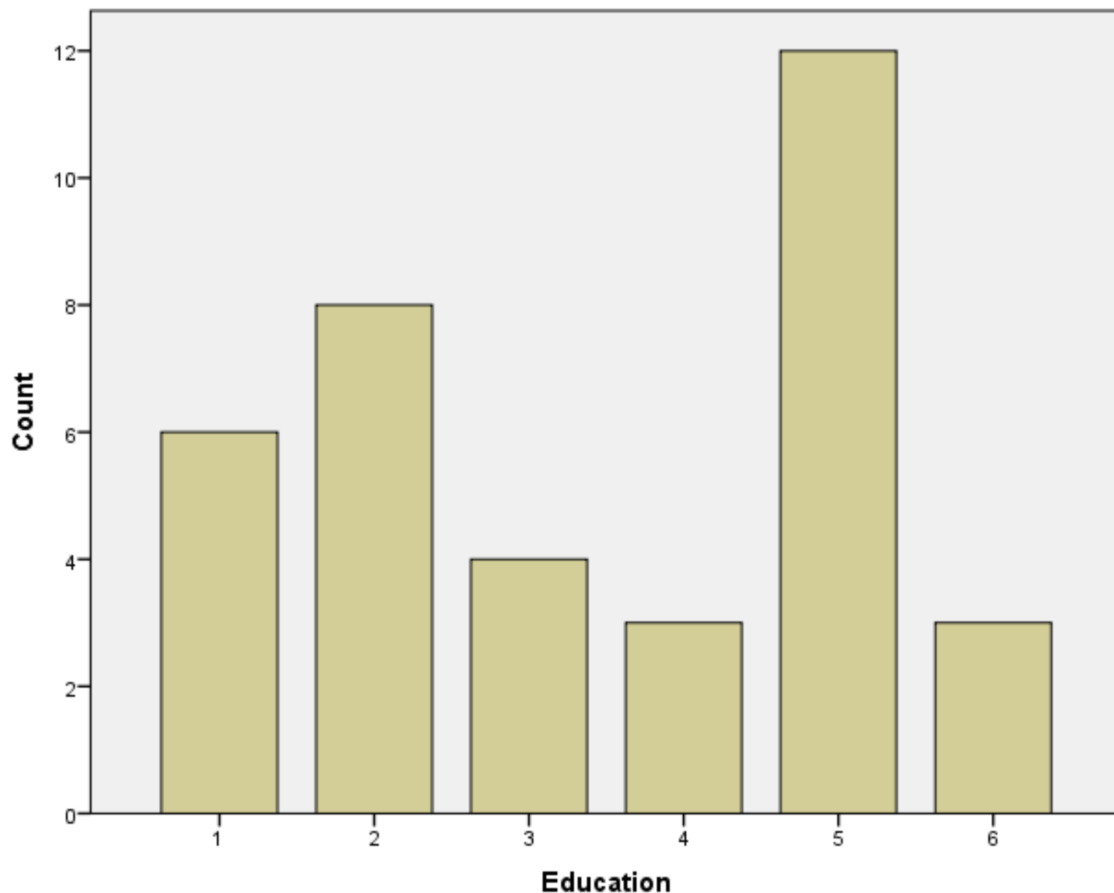
include any identifiable information about participants such as their names and addresses. To protect confidentiality, data received from survey was kept in locked cabinet.

Sample

By utilizing a quantitative non-probability design, this research project studied the variable that shapes views on seeking mental health services in the Somali population living in the United States. The participants were individuals from Somalia who have been living in the U.S. There were 36 participants in the research. All participants were at least 18 years old. The participants had been in the U.S for at least a year and were able to complete the survey without any assistance from another party. The researcher obtained the sample by handing out the survey for participants to complete. Researcher started collecting data after the approval of Institutional Review Board from University of St. Thomas.

Demographics. Twenty respondents (55.6%) identified themselves as male and sixteen (44.4%) identified themselves as female. The ages of the respondents ranged from 19-67. Of the 36 respondents, the mean age group was 33.9 with a standard deviation of 10.960. The duration of the respondents living in the United States ranged from 1-27 years. Of the 36 respondents, the mean of duration was 12.78 with a standard deviation of 6.543. The majority of the respondents (33.3%) had a Bachelor's degree (Figure 1).

Figure 1. Education



Data Collection Instrument and Process

The researcher did a snowball method survey in the Somali community. The researcher provided the survey to Somali people who speak English and who did not need assistance in completing it. The survey questions developed by the researcher included six questions that were reviewed and approved by Dr. Karen Carlson, the Research chair as required by the IRB (see Appendix B for survey questions). The questions were developed as an outcome of questions that surfaced from the literature review and

addressed individual's views on seeking out mental health services: specifically looking into the Somali community for this research.

The Acculturation (Recoded) is a four question scale that assesses individuals' attitude towards mental illness. The scale includes four negative statements (e.g 'I would avoid someone who has symptoms such as (feelings of helplessness and hopelessness, seeing or hearing things that do not exist, having confused and disturbed thoughts, lack of interest in activities that was once enjoyed, trouble concentrating, trouble sleeping, negative feelings about yourself or other people)', 'A person should hide from other people if they have been treated for symptoms such as (feelings of helplessness and hopelessness, seeing or hearing things that do not exist, having confused and disturbed thoughts, lack of interest in activities that was once enjoyed, trouble concentrating, trouble sleeping, negative feelings about yourself or other people)'). Individuals were asked to rate each statement using a five-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Responses to these negative statements were reverse coded. Higher scores indicated more positive attitudes toward mental health services.

Data Analysis plan

The researcher used the statistical software program Statistical Package for the Social Sciences (SPSS) to analyze the collected data. To analyze the frequency distribution, descriptive statistics was used. To investigate the relationship between the dependent and independent variables, inferential statistics was used.

Results

Table 1.1 and 1.2 shows the results for the one-way ANOVA comparing views on mental health care and education levels. The table shows the results for the one-way ANOVA comparing views on the dependent variables, mental health care. Mental health care is split in to two categories, traditional views on mental health and western views on mental health. The independent variable is education, categorized into 3 groups, some high school, some college, and Master's degree.

Traditional views on mental health shows that the difference between some high school and some college mean Individual Scale scores is .218 points. The p-value for the difference between these two groups' Individual Scale scores is p=.980. Therefore there is not a significant difference between the groups with some high school and some college mean Individual Scale scores.

Traditional views on mental health also shows that some high school and masters mean Individual Scale scores is 1.429 points. The p-value for the difference between these two groups' Individual Scale scores is p=.765. Therefore there is not a significant difference between the groups with some high school and masters mean Individual Scale scores.

Traditional views on mental health also shows that some college and masters mean Individual Scale scores is 1.211 points. The p-value for the difference between these two groups' Individual Scale scores is p=.817. Therefore there is not a significant difference between the groups with some college and masters mean Individual Scale scores.

For traditional views on mental health, the p-value on all comparisons greater than P=.05 indicating that there is not a statistically significant difference between the groups. Therefore, we fail to reject the null hypothesis and conclude that there is no significant difference between traditional views one mental health and education level.

Western views on mental health shows that the difference between some high school and some college mean Individual Scale scores is .545 points. The p-value for the difference between these two groups' Individual Scale scores is p=.776. Therefore there is not a significant difference between the groups with some high school and some college mean Individual Scale scores.

Western views on mental health also shows that the groups with some high school and masters mean Individual Scale scores is .405 points. The p-value for the difference between these two groups' Individual Scale scores is p=.958. Therefore there is not a significant difference between some high school and masters mean Individual Scale scores.

Western views on mental health also shows that s the groups with ome college and masters mean Individual Scale scores is .140 points. The p-value for the difference between these two groups' Individual Scale scores is p=.995. Therefore there is not a significant difference between some college and masters mean Individual Scale scores.

For western views on mental health, the p-value is >.001, indicating that there is not a statistically significant difference between the groups. Therefore, we fail to reject the null hypothesis and conclude that there is no significant difference between western views one mental health and education level.

Table 1.1

ANOVA for Views on Mental Health Care and Education Levels

		Sum of Squares	df	Mean Square	F	Sig.
Traditional Views on Mental Health	Between Groups	5.052	2	2.526	.246	.783
	Within Groups	338.586	33	10.260		
	Total	343.639	35			
Western Views On Mental Health	Between Groups	2.418	2	1.209	.234	.792
	Within Groups	170.332	33	5.162		
	Total	172.750	35			

Table 1.2

Tukey for Views on Mental Health Care and Education Levels

Dependent Variable	(I) Education	(J) Education	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Traditional Views on Mental Health	Some High School	Some College	.218	1.128	.980	-2.55	2.99
		Masters	1.429	2.038	.765	-3.57	6.43
	Some College	Some High School	-.218	1.128	.980	-2.99	2.55
		Masters	1.211	1.990	.817	-3.67	6.09
	Masters	Some High School	-1.429	2.038	.765	-6.43	3.57
		Some College	-1.211	1.990	.817	-6.09	3.67
Western Views On Mental Health	Some High School	Some College	-.545	.800	.776	-2.51	1.42
		Masters	-.405	1.445	.958	-3.95	3.14
	Some College	Some High School	.545	.800	.776	-1.42	2.51
		Masters	.140	1.411	.995	-3.32	3.60
	Masters	Some High School	.405	1.445	.958	-3.14	3.95
		Some College	-.140	1.411	.995	-3.60	3.32

Table 2 shows the inferential statistics of the relationship between the two variables, Acculturation (Recoded) and Duration. The Pearson correlation .402 indicates a moderate, positive relationship. This correlation indicates that one variable increases as the other increases. The relationship between the two variables is statistically significant since the p-value is less than .05.

Table 2

Relationship between Acculturation and Duration

		Acculturation RC	Duration
Acculturation RC	Pearson Correlation	1	.402*
	Sig. (2-tailed)		.017
	N	35	35
Duration	Pearson Correlation	.402*	1
	Sig. (2-tailed)	.017	
	N	35	36

*. Correlation is significant at the 0.05 level (2-tailed).

Table 3.1 and 3.2 shows the results for the one-way ANOVA comparing acculturation and education. The table shows the results for the one-way ANOVA comparing the dependent variable, acculturation and the independent variable, education that is categorized into 3 groups, some high school, some college, and Master's degree.

The dependent variable acculturation shows that the difference between groups with some high school and some college mean Individual Scale scores is 4.166 points. The p-value for the difference between these two groups' Individual Scale scores is p=.036. Therefore there is a significant difference between some high school and some college mean Individual Scale scores.

Acculturation also shows that groups with some high school and masters mean Individual Scale scores is 7.833 points. The p-value for the difference between these two groups' Individual Scale scores is p=.026. Therefore there is a significant difference between some high school and masters mean Individual Scale scores.

Acculturation also shows that groups with some college and masters mean Individual Scale scores is 3.666 points. The p-value for the difference between these two groups' Individual Scale scores is p=.401. Therefore there is not a significant difference between some college and masters mean Individual Scale scores.

For acculturation, the p-value is .009, indicating that there is not a statistically significant difference between the groups. Therefore, we fail to reject the null hypothesis and conclude that there is no significant difference between acculturation and education level.

Table 3.1

ANOVA for Acculturation (Recoded) and Education

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	219.376	2	109.688	5.432	.009
Within Groups	646.167	32	20.193		
Total	865.543	34			

Table 3.2

Tukey for Acculturation (Recoded) and Education

(I) Education	(J) Education	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Some High School	Some College	-4.16667*	1.60130	.036	-8.1016	-.2317
	Masters	-7.83333*	2.85889	.026	-14.8587	-.8080
Some College	Some High School	4.16667*	1.60130	.036	.2317	8.1016
	Masters	-3.66667	2.80227	.401	-10.5529	3.2196
Masters	Some High School	7.83333*	2.85889	.026	.8080	14.8587
	Some College	3.66667	2.80227	.401	-3.2196	10.5529

*. The mean difference is significant at the 0.05 level.

Table 4 shows that the r-value for the variables Acculturation (Recoded) and Traditional Views on Mental health is .045, while the r-value for Acculturation (Recoded) and Western Views on Mental health is .335. The p-value for the variables Acculturation (Recoded) and Traditional Views on Mental health is p=.795, and the p-value for the variables Acculturation (Recoded) and Western Views on Mental health is p=.049. In the correlation between Acculturation (Recoded) and Western Views on Mental health, the r-value is .335, which is moderate positive relationship, and the p-value is .049, which indicates it is a statistically significant relationship.

Table 4

Relationship between Acculturation (Recoded), Traditional Views on Mental Health and Western Views on Mental Health

		Acculturation RC	Traditional Views on Mental Health	Western Views On Mental Health
Acculturation RC	Pearson Correlation	1	.045	.335*
	Sig. (2-tailed)		.795	.049
	N	35	35	35
Traditional Views on Mental Health	Pearson Correlation	.045	1	-.163
	Sig. (2-tailed)	.795		.342
	N	35	36	36
Western Views On Mental Health	Pearson Correlation	.335*	-.163	1
	Sig. (2-tailed)	.049	.342	
	N	35	36	36

*. Correlation is significant at the 0.05 level (2-tailed).

Table 5.1 and 5.2 show the results of the T-test comparing the mean of Acculturation (Recoded) Scale Scores of the respondents who chose family as best resource and respondents who chose mental health professional as best resource. The mean score of respondents who perceived family as best resource was 12.42. The mean score of respondents who perceived mental health professional as best resource was 18.18. The difference between the mean scores was -5.76.

The 19 respondents who chose family as a best resource had a standard deviation of 4.857 from their mean of 12.42. The mean of the standard deviation was 1.114. The 11

respondents who chose mental health professional as their best option had a standard deviation of 3.544 from their mean of 18.18. The mean of this standard deviation was 1.068.

The Levene's Test of Equality of Variance for the Independent sample T-test is .127. Since .127 is greater than .05, the Levene's test is not significant. Therefore, the p-value for this is T-test is .002. Since the p-value is less than .05, the result of this data is statistically significant. As a result we reject the null hypothesis that there is difference between respondents who chose family as a best resource and respondents who chose mental health professional as a best resource on their Acculturation (Recoded) scale scores. Therefore, there is significant difference between respondents who had perceived family as best resource and respondents who perceived mental health professional as best resource.

Table 5.1

Group Statistics for Acculturation (Recoded) and Best Resource T-test

	Best Resource	N	Mean	Std. Deviation	Std. Error Mean
Acculturation RC	Family	19	12.4211	4.85702	1.11428
	Mental Health Professional	11	18.1818	3.54452	1.06871

Table 5.2

Acculturation (Recoded) Scale Score and Best Resource T-test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Acculturation RC	Equal variances assumed	2.478	.127	-3.430	28	.002	-5.76077	1.67956	-9.20119	-2.32034
	Equal variances not assumed			-3.731	26.295	.001	-5.76077	1.54394	-8.93265	-2.58888

Table 6.1 and 6.2 show the results of the T-test comparing the mean of Acculturation (Recoded) Scale Scores of the respondents who chose family as best resource and respondents who chose religious leader as best resource. The mean score of respondents who perceived family as best resource was 12.42. The mean score of respondents who perceived religious leader as best resource was 12.33. The difference between the mean scores was .087.

The 19 respondents who chose family as a best resource had a standard deviation of 4.857 from their mean of 12.42. The mean of the standard deviation was 1.114. The 3 respondents who chose religious leader as their best option had a standard deviation of 3.214 from their mean of 12.33. The mean of this standard deviation was 1.855.

The Levene's Test of Equality of Variance for the Independent sample T-test is .285. Since .285 is greater than .05, the Levene's test is not significant. Therefore, the p-value for this is T-test is .976. Since the p-value is greater than .05, the result of this data are not statistically significant. As a result we fail reject the null hypothesis that there is no difference between respondents who chose family as a best resource and respondents who chose religious leader as a best resource on their Acculturation (Recoded) scale scores. Therefore, there is not a significant difference between respondents who had perceived family as best resource and respondents who perceived religious leader as best resource.

Table 6.1

Group Statistics for Acculturation (Recoded) and Best Resource T-test

	Best Resource	N	Mean	Std. Deviation	Std. Error Mean
Acculturation RC	Family	19	12.4211	4.85702	1.11428
	Religious Leader	3	12.3333	3.21455	1.85592

Table 6.2

Acculturation (Recoded) Scale Score and Best Resource T-test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Acculturation RC	Equal variances assumed	1.205	.285	.030	20	.976	.08772	2.93146	-6.02721	6.20264
	Equal variances not assumed			.041	3.649	.970	.08772	2.16473	-6.15750	6.33294

Table 7.1 and 7.2 show the results of the T-test comparing the mean of Acculturation (Recoded) Scale Scores of the respondents who chose religious leader as best resource and respondents who chose mental health professional as best resource. The mean score of respondents who perceived religious leader as best resource was 12.33. The mean score of respondents who perceived mental health professional as best resource was 18.18. The difference between the mean scores was -5.84.

The 3 respondents who chose religious leader as a best resource had a standard deviation of 3.214 from their mean of 12.33. The mean of the standard deviation was 1.855. The 11 respondents who chose mental health professional as their best option had a standard deviation of 3.544 from their mean of 18.18. The mean of this standard deviation was 1.068.

The Levene's Test of Equality of Variance for the Independent sample T-test is .884. Since .884 is greater than .05, the Levene's test is not significant. Therefore, the p-value for this is T-test is .024. Since the p-value is less than .05, the result of this data is statistically significant. As a result we reject the null hypothesis that there is difference between respondents who chose religious leader as a best resource and respondents who chose mental health professional as a best resource on their Acculturation (Recoded) scale scores. Therefore, there is a significant difference between respondents who had perceived religious leader as best resource and respondents who perceived mental health professional as best resource.

Table 7.1

Group Statistics for Acculturation (Recoded) and Best Resource T-test

	Best Resource	N	Mean	Std. Deviation	Std. Error Mean
Acculturation RC	Religious Leader	3	12.3333	3.21455	1.85592
	Mental Health Professional	11	18.1818	3.54452	1.06871

Table 7.2

Acculturation (Recoded) Scale Score and Best Resource T-test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Acculturation RC	Equal variances assumed	.022	.884	-2.572	12	.024	-5.84848	2.27428	-10.80371	-.89326
	Equal variances not assumed			-2.731	3.470	.061	-5.84848	2.14163	-12.17053	.47356

Discussion

Summary

The purpose of this study was to examine Somali people views on seeking mental health services and to examine if their views related to their level of acculturation. The result suggests that there is not significant difference between respondent with traditional views on mental health and the level of education that they have attained. It also suggests that there is not a significant difference between with western views on mental health and the level of education that they have attained. The results for relationship between acculturation and duration showed that the relationship between two variables was statistically significant. The respondents who were here longer were more likely to disagree with negative attitude towards mental illness.

The overall results for acculturation (recoded) and education shows that there is no significant difference between respondent's attitudes toward mental illness and the level of education they have attained. However, there was some significant difference between those who had attained some high school and those who had attained a master's degree when it comes to their attitude towards mental illness. Those who had attained a master's degree were more likely to disagree with negative attitude towards mental illness than those who had attained a high school diploma.

The relationship between acculturation, traditional views on mental health, and western views on mental health showed that there is no significant relationship with traditional views on mental health. However, there was a statistically significant relationship between acculturation and western views on mental health. These respondents who were more likely to seek assistance from western health for mental illness were more likely to disagree with negative attitudes toward mental illness.

There was a significant difference between acculturation and best resource T-test between family and mental health professional. There was a difference between respondents who chose family as best resource and those who chose mental health professional as best resource. Respondents who chose mental health professional as best resource were more likely to disagree with negative attitudes toward mental illness.

There was not a significant difference between acculturation and best resource T-test between family and religious leader. There was not a difference between respondents who chose family as a best resource and those who chose religious leader as best resources in regards to their attitude towards mental illness.

There is a significant difference between acculturation and best resource T-test between religious leader and mental health professional. There was a difference between respondents who chose religious leader as best resource and those who chose mental health professional as best resource. Those who chose mental health professional as best option were more likely to disagree with negative attitude towards mental illness.

Strengths

There was a number of strengths to this research being conducted. Since there is not much research done on seeing if there is a correlation between acculturation and Somali people's views on seeking mental health services, this research was able to contribute to this limited knowledge base. In using a quantitative approach in this study, the researcher was able to acquire thorough information from individuals who participated in the topic to add to comprehensive material to the field of literature. By using a survey, the researcher was able to explore ideas that might be new or unknown from what the participants had reported. Another strength was that all the participants were Somali.

Limitations

This research design had some limitations. A limitation of this study was that individuals who could not read English were not able to participate. This study is centered on small sample of individuals from Somalia who live in the United States; therefore, it is difficult to generalize the conclusions of this study to the general Somali population who live in Somalia or in the United States.

Implications for Practice/ Future Research

The findings of this research show that Somali individuals who reside in the United States have different views and beliefs about mental illness. It is important for professionals to gain familiarity about various views and beliefs that other ethnic communities hold about mental disorders in the United States, such as those in the Somali Community. Mental health service providers will benefit from learning about views and beliefs about mental disorders of different ethnic communities because it will help them provide culturally knowledgeable care to the individuals that they serve.

Future implications for practice include psycho-education to individuals from Somalia regarding mental illness. There is a need for awareness to be brought to the Somali community; Somalis need to be educated about mental illness and about treatment and medication. Due to the fear of being stigmatized with mental illness, there might be some Somali people who might not seek mental health care. The community needs to have a facilitated dialogue about their views on mental illness and how to break the stigma behind it. Somali individuals coming from a different cultural background might have a hard time understanding how seeking mental health assistance for themselves could be of benefit to their health because it is something that they are not used to doing; Somalis are used to seeking out religious leaders and traditional healers.

Mental health practitioners could benefit from trainings that could increase their awareness about obstacles that are faced by Somali refugees in the United States. There is also a need for Somali people to be comfortable and be able to have an open discussion with their practitioners about what their beliefs and traditional practices are. Language barrier is an obstacle that Somali individuals might face when being provided with health

services. Mental health practitioners should integrate approaches to guarantee that clients are fully aware and understand what choices they are being offered so that they can make sound decision. Another difficulty faced with the language barrier is the use of interpreters. There is a possibility that interpreters might not be able to fully interpret to the client what the practitioner is saying if they are not full aware of medical jargon that is being used. Mental health practitioners should use proficiently trained interpreters when working with Somali individuals who are not fluent in English.

There are implications from this study for additional social work research. This study showed that Somali individuals who resided in the United States longer did not have negative perceptions towards mental illness. Also individuals who believed in seeking western mental health assistance did not have negative perceptions towards mental illness. There is a dire need for more research to be done on Somali mental health. There should be further research done on acculturation and Somali individual's views on seeking mental health services.

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Appendix A. Informed Consent Form

CONSENT FORM
UNIVERSITY OF ST. THOMAS
[Views on Seeking Mental Health Services in the Somali Community]
[674152-1]

I am conducting a study about what are the views on seeking mental health services amongst Somali individuals. I invite you to participate in this research. You were selected as a possible participant because you are an individual from Somalia living in the U.S. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Hamdi Adan, a graduate student at the School of Social Work, Catherine University/University of St. Thomas and supervised by Karen Carlson.

Background Information:
The purpose of this study is: to see if Somali person's level of acculturation relates to attitudes towards seeking mental health services. The study will be looking to see if there is a correlation between age differences, gender, education levels, and duration of being in the U.S among Somali individuals and their views on seeking out mental health services.

Procedures:
If you agree to be in this study, I will ask you to do the following things: participate in a one-time 10 minute survey. I will provide you with a paper survey to fill out. Prior to beginning the survey, I will review the consent form with you and ask you to sign.

Risks and Benefits of Being in the Study:
The study has no risks.
The study has no direct benefits.

Confidentiality:
The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include a survey and consent form. Only the researcher will have access to the survey and the signed consent form that you provide which will be kept in a locked cabinet. Survey will be destroyed after completing the research on May 18, 2015. Consent form will be retained for three years per federal law.

Voluntary Nature of the Study:
Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas. If you decide to participate, you are free to withdraw at any time without penalty. You may withdraw from the study by discontinuing the completion of the survey. You are also free to skip any questions I may ask. Should you decide to withdraw data collected about you will not be used in this data. You may withdraw from the survey

until February 1st by calling me or emailing me. Since your name is not on the survey, I will use your ID number on the survey to remove data from the study.

Contacts and Questions
My name is Hamdi Adan. You may ask any questions you have now. If you have questions later, you may contact me at. Specific questions to my instructor Karen Carlson could be addressed to carl1307@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6038 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age.

______________________________ ________________
Signature of Study Participant **Date**

____
Print Name of Study Participant

______________________________ ________________
Signature of Researcher **Date**

Appendix B. Survey

Demographics

What is your gender?
____Male ____Female

What is your age? ____________

How old were you when you came to the United States: ___________

How long have you lived in the United States?____________

What is your highest level of education achieved?

- ☐ Less than High School
- ☐ High School Diploma
- ☐ Some College
- ☐ 2-year College Degree
- ☐ 4-year College Degree
- ☐ Master Degree
- ☐ Doctoral Degree

1) Please indicate how strongly you would agree or disagree about someone you know seeking assistance for symptoms of mental illness (feelings of helplessness and hopelessness, seeing or hearing things that do not exist, confused and disturbed thoughts, lack of interest in activities that was once enjoyed, trouble concentrating, trouble sleeping, negative feelings about yourself or other people, etc.) from the following:

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
Family	1	2	3	4	5
Friends	1	2	3	4	5
Somali Community	1	2	3	4	5
Traditional Healer	1	2	3	4	5
Religious Leader	1	2	3	4	5
Mental Health Professional	1	2	3	4	5
General Physician	1	2	3	4	5
Medical Doctor	1	2	3	4	5

2) What do you believe to be the best option for someone seeking out assistance for symptoms of mental illness (feelings of helplessness and hopelessness, seeing or hearing things that don't exist, having confused and disturbed thoughts, lack of interest in activities that was once enjoyed, trouble concentrating, trouble sleeping, negative feelings about yourself or other people, etc.). (Please select only one option)

□ Family
□ Friends
□ Somali Community
□ Traditional Healer
□ Religious Leader
□ Mental Health Professional
□ General Physician
□ Medical Doctor
□ Other: Please Specify ____________________

3) I would avoid someone who has symptoms such as (feelings of helplessness and hopelessness, seeing or hearing things that do not exist, having confused and disturbed thoughts, lack of interest in activities that was once enjoyed, trouble concentrating, trouble sleeping, negative feelings about yourself or other people).

☐ Strongly Agree
☐ Agree
☐ Neither Agree or Disagree
☐ Disagree
☐ Strongly Disagree

4) A person should hide from other people if they have been treated for symptoms such as (feelings of helplessness and hopelessness, seeing or hearing things that do not exist, having confused and disturbed thoughts, lack of interest in activities that was once enjoyed, trouble concentrating, trouble sleeping, negative feelings about yourself or other people).

☐ Strongly Agree
☐ Agree
☐ Neither Agree or Disagree
☐ Disagree
☐ Strongly Disagree

5) It is okay to not be around someone if they have symptoms such as (feelings of helplessness and hopelessness, seeing or hearing things that do not exist, having confused and disturbed thoughts, lack of interest in activities that was once enjoyed, trouble concentrating, trouble sleeping, negative feelings about yourself or other people).

☐ Strongly Agree
☐ Agree
☐ Neither Agree or Disagree
☐ Disagree
☐ Strongly Disagree

6) Mental Illness is a matter that should not be discussed.

☐ Strongly Agree
☐ Agree
☐ Neither Agree or Disagree
☐ Disagree
☐ Strongly Disagree