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Investigating Dropout From Mental Health Care Among Somali Immigrants in the United States

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Abstract

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MS, University of Phoenix, 2009

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

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Abstract

African immigrants and refugees drop out of mental health care at a higher rate than other populations in the United States. However, there is a significant lack of research on mental health treatment or reasons for dropping out of mental health treatment among African immigrants and refugees. The purpose of this study was to investigate the lived experiences with mental health treatment of Somali immigrants and refugees living in the United States. Eight Somali immigrants and refugees living in a midwestern state, were interviewed, and their accounts with the mental health system in the United States were recorded. A phenomenological method was used to develop and then to analyze data from the interview questions and generate common themes across participants. The findings revealed that respondents perceived mental health challenges in a negative way. Many respondents thought that such mental health diseases were caused by being cursed or demon possessed, and that these challenges were compounded by culture shock and language barriers for the Somali immigrants and refugees, and they perceived a lack of cultural sensitivity and awareness among mental health providers. Participants also perceived the mental health care system and providers in a negative way, because they believed providers lacked the cultural knowledge to support them. Similar studies reviewed in literature showed a strong interplay of both cultural and religious factors driving the high dropout rate from mental health treatment among immigrants and refugees. Information from this study could help mental health systems and individual practitioners to better understand the barriers and cultural values that can interfere with successful mental health treatment for Somali immigrants and refugees, and aid in expanding the discussion about mental health treatment for African immigrants and refugees.

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Chapter 1: Introduction to the Study

Introduction

Approximately 33.1 million immigrants and refugees live in the United States (Urban Institute, 2009). These estimates also show that of those 33.1 million, 20% are African immigrants and refugees with the Somali immigrant and refugee population being among the largest (Urban Institute, 2009). With a sizable Somali refugee and immigrant population, scholars have sought to better understand the influence of factors such as mental health problems among Somali immigrants and refugees in United States (Zeidner & Hammer, 1990). The focus of this study was on perceptions and experiences of Somali immigrants and refugees in mental health treatment.

Mental health problems remain a major concern in the United States, especially among racial ethnic minority groups, because these groups are often underserved, with observable negative effects on Somali immigrants and refugees (Jacob, Sharan, & Miraza, 2008; Omi & Winant, 1986). Research has shown that mental health disparities exist more often in population groups that have limited access to mental health care services, which is frequently seen where Somali immigrants and refugees live (Cole, 1998). Furthermore, members of minority racial and ethnic groups report more negative experiences in mental health services and treatment outcomes than do members of nonminority groups (World Health Organization [WHO], 2001). Somali immigrants and refugees have a higher incidence of mental illness (major depression, posttraumatic stress and general anxiety) than nonmarginalized groups because they often do not receive the treatment they need (Keyes, 2000). Limited research has been done to determine which

mental health treatments are most effective for Somali immigrants and refugees, thus contributing to difficulties for these groups to access and maintain effective treatment (Baicker, Chandra, & Skinner, 2005). Additional concerns surround the lack of research available on various significant mental health problems in these underserved populations (Jacob et al., 2008).

Background of the Study

Ethnic minority populations, including Somali immigrants and refugees, are underserved in mental health treatment due to multiple factors, including enormous language barriers and the lack of understanding of cultural differences by mental health providers, including psychologists, counselors, clinical social workers, and psychiatrists (Cooper, Beach, Johnson, & Inui, 2009). Evidence also suggests that biological ethnic differences that occur in response to standard medications are likely not to be taken into consideration when a person is treated in a psychopharmacological manner (Herbeck, 2004). Refugees and immigrants in the United States drop out of mental treatment after the first session significantly more than other groups, because mental health practitioners are culturally unfamiliar with the importance of race and ethnicity among Somali immigrants and refugees (Kovacey & Shute, 2004). The result is an ethno-racial gap in clinical practice (Montalvo, 2009). These challenges, both pharmacological and sociocultural, mean that the level of efficacy for psychological care for Somali immigrants and refugee backgrounds is likely to be lower than that for United States born citizen, and therefore lack of cultural competency can eliminate client commitment to ongoing participation in mental health treatment.

Challenges for Somali Immigrants and Refugees With Mental Health Needs

Somali immigrants and refugees face enormous challenges when adjusting to life in the United States (Molina, 2010). The challenges are compounded when individuals also suffer from mental illness and need treatment. Although immigrants in the United States come from many African countries, much of the research has been conducted with Somali immigrants and refugees, as this is one of the largest and fastest-growing population groups of African immigrants and refugees in the United States. The process of immigrating to a new country also involves the loss of social status, and loss of homeland (WHO, 2013). Researchers from the Census for Bureau of Refugees and Immigrants (2013) revealed that mental health issues among the growing number of refugees and immigrants to the United States have presented enormous challenges. The United Nations High Commissioner for Refugees (UNHCR) noted in October 2013 that there are "around 84,000 Somali refugees living in the United States in 25 years and 43,682, came since September 11, 2010" (p. 192). The U.S Department of Health and Human Services (2001) also stated that "Post-Traumatic Stress Disorder (PTSD) among immigrant and refugee populations ranges from 39% to 100% (compared with 1% in the general population) while rates of depression range between 47% and 72% compared to that in the general population" (p. 201).

Some African immigrants and refugees often have suffered the trauma of civil war and have encountered violence, malnutrition or famine, political persecution, and torture (WHO, 2010). The Rockville, Maryland, office of the surgeon general (2013) also reported an increasing and overwhelming burden of mental illness among Somali

immigrants and refugees in the United States. Without a complete understanding of the cultural background, beliefs and experiences of Somali (or other) immigrants and refugees, it is difficult for mental health practitioners to effectively address their problems.

A second issue related to mental health treatment for Somali immigrants and refugees is a self-imposed stigma that individuals or communities may create (WHO, 2010). Individuals expect they will not be understood. They expect to be viewed as less important, in terms of social status or abilities. The result is greater social isolation that then worsens mental health conditions (WHO, 2009).

Challenges Within the Patient-Clinician Relationship

Research suggests that several aspects of the patients-physician relationships contribute to racial ethnic problems in mental health services (Cooper et al., 2009). On a fundamental level, it is important for mental health service providers to develop proficiencies applicable to multicultural patient conceptualization and assessment and policy interventions to reduce the negative effects of mental health disorders among Somali immigrant and refugee patients (Patel & Kleinman, 2009). Biases created by cultural differences and language barriers often result in mental health care professionals providing poorer quality treatment to Somali immigrants and refugees (African Immigrant and Refugee Foundation [AIRF], 2000; Keyes, 2000). Evidence suggests that physicians and other mental health practitioners fail to fully understand the mental status or needs of Somali immigrant and refugee patients because of their assumptions that influence how they treat this population group (Keyes, 2000).

In addition, mental health practitioners may believe that they have inadequate skills to successfully treat mental health problems of Somali immigrants and refugees in United States. As a result, many Somali immigrants and refugees have not been receiving adequate treatment to overcome the impact of mental illness such as major depression, posttraumatic stress, and general anxiety (Cook, McGuire, & Miranda, 2004).

Failing to account for worldview differences may put mental health physicians and other health professionals at risk of being ineffective and possibly harming their patients (Williams, 2005). Clinicians may have gaps in their knowledge of sensitivity to cultural differences (Harrison & Samuel, 2000). To further this problem, these problems in treatment may be unknown to mental health practitioners. These untreated mental health issues can negatively affect individuals' lives, which leads to more functional limitations, not only for the people involved, but also for the communities and societies in which patients live (Harrison & Samuel, 2000).

Use of Assessment IQ Tests and Bias in Testing

In current mental health practice, IQ tests are used in the diagnosis and treatment planning process. The effects of these tests on immigrant and refugee groups may be harmful. Historically, assessments such as interviewing, intelligence testing, personality testing, and other instruments to add to diagnosis have been used to sort individuals, as in eugenics or to impose restrictions on immigration (APA, 2005). In addition, IQ tests have not been developed with norms drawn from immigrants and refugee population groups (Kamin, 1974). Therefore, when a client's score on an IQ test is compared with a normative sample, the client is being compared with individuals with different

experiences and cultural background. Finally, current uses of IQ assessment tests in a client's non-native language continue to be problematic. IQ testing results can be inaccurate or biased, affecting Somali immigrants and refugee patients, and leading to inappropriate treatment (American Psychological Association [APA], 2010). Research also shows that historical messages of inferior IQs of Somali immigrant and refugee patients cause health practitioners to treat these minority groups with less respect and dignity in mental care facilities (Dana, 2005; Tate, 2001).

Problem Statement

Somali immigrants and refugees face significant challenges when adjusting to life in the United States; this is particularly true if individuals also have mental health problems. They often experience stigma and discrimination within their own groups, which can lead to exclusion or discourage them from seeking treatment (Balsa, McGuire, & Meredith, 2005). The U.S. Office of Refugee Resettlement 1983 to 2004 noted that of the 55,036 Somali refugees resettled in the United States, 80% have a high risk of suicide, compared with 40% of Whites and Asians (U.S Office of Refugee Resettlement, 2004). The Refugee Health Technical Assistance Center (RHTA) between 2009 and 2011 found that 13 refugees from Somalia had committed suicide making the rate of 31.5/100,000 compared with 11/100,000 of people in the overall U.S. population. According to WHO (2013), Somali immigrants and refugees in the United States now have the highest risk of suicide. Such examples illustrate the prevalence of mental health problems among Somali immigrants and refugee population groups and emphasize the importance of high quality and culturally sensitive mental health treatment.

A lack of research identifying underlying factors among Somali immigrants and refugees that promote mental health disorders contributes to the problem of inappropriate treatment (William, 1990). In addition, insufficient research explores the perceptions and experiences of Somali immigrants and refugees with respect to mental health treatment. In this study, I interviewed Somali immigrants and refugees, in a culturally sensitive manner, to gain greater understanding of their mental health treatment needs, which may then promote progress to successful mental health treatment.

Purpose of the Study

My purpose in this study was to investigate the lived experiences with mental health treatment among Somali immigrants and refugees living in the United States. I selected Somalis who are settled in a midwestern state, as the sample for this study. I explored issues related to higher treatment dropout rates among Somali immigrants and refugee and it generated information about patient lived experiences and perceptions that provided an initial look at the reasons for dropping out.

Although I did not use randomized experimental procedures to determine causes of higher treatment dropout rates among Somali immigrants and refugees, information generated about patient perceptions has provided an initial look at reasons for dropping out. Information from this study could help educate mental health practitioners and help them provide higher quality treatment to Somali immigrants and refugees. This information will also provide education for refugees and immigrants that could help them access mental health interventions. The results of this study could lead to positive social change to improve the overall quality of life for Somali immigrants and refugees in their

communities. Information from this study could provide support for strategies and policy actions to reduce problems in mental health treatment for immigrants and refugees in the United States and around the globe.

Eight Somali immigrants and refugees were interviewed and their accounts of their experience with the mental health system in the United States was told and audio recorded. Interviews were open ended and a content analysis of them was performed. Respondents were selected from among Somali immigrants or refugees aged 18 to 35 years who have a history of dropping out of mental health care. Those currently struggling with physical, psychological, and emotional behavioral problems were targeted.

Research Questions

1. How do Somali immigrant and refugee patients describe their lived experience with and perception of mental health problems?
2. What are the participants' lived experiences with and perceptions of Somali immigrant and refugee patients regarding mental health treatment offered by mental health providers in the United States?
3. How do Somali immigrants and refugees describe factors related to dropping out of mental health?

These questions are important to this research because of the limited literature on African immigrants and refugee patients in the United States. Mental health disparities of Somali immigrants and refugee patients have created significant public health problems because they result in a higher rate of mental illness. In a study by Cole (1998), clinicians

sought to probe their attitudes and perceptions about social problems to understand what Somali immigrant and refugee patients experience as they seek mental health treatment supportive services.

Theoretical and/or Conceptual Framework for the Study

An essential component for this study is consideration of the complexities of the forced migration experience of Somali immigrants and refugees, which includes contextual factors such as cultural background, language barriers, historical background, political instabilities, and economic conditions that led to this forced migration from Somalia to the United States. Furthermore, consideration of the political instabilities and conditions that led to Somali refugees and immigrants leaving their home country of origin and the effects these have on resettlement and mental health outcomes is essential to providing appropriate mental health treatment (Cole, 1998). An understanding about what the mental health treatment experiences are like for African immigrants and refugees will provide contextual information to develop strategies that are helpful and relevant for this population.

Minimizing barriers that Somali immigrants and refugees experience during the mental health treatment process allows them to gain access to those resources, such as culturally sensitive health care services, that contribute to health and well-being. The knowledge derived from this study will enhance understanding of positive social change by improving the status of mental health treatment for other immigrants and refugees internationally. This knowledge will contribute to theoretical understanding for current and incoming practitioners about how to give higher quality treatment to Somali

immigrant and refugee patients. Information from this study could also extend the theoretical knowledge about Somali immigrant and refugees situational transitions in the United States and around the globe (WHO, 2010).

Nature of the Study

A phenomenological approach was used to build an understanding through interviews of the marginalized population within their environment. The data analysis strategy for qualitative data found themes of experiences and the perception of Somali immigrants and refugees towards mental health services in a midwestern state. This qualitative methodology was conducted among Somali refugees and immigrants between the ages of 18 and 35 years, to investigate how the perceived effectiveness of mental health treatment is influenced by cultural and language differences between client and mental health professionals. Other factors impacting the dropout rate within the chosen age range of 18 to 35 years tend to be busier lives and other social activities among youth not up to coping up with cultural shock and mental health practitioners who are unable to produce proper treatments as they lack specialized skills and the resources to deal with the complexities of Somali immigrants and refugees (Michalopoulou, Falzarano, & Rosenberg, 2009). Qualitative research is useful for helping researchers understand biases to educate mental health practitioners and help them provide higher quality treatment and can also be used to identify information to provide effective education to Somali immigrants and refugee patients and help them access mental health interventions and pre-service programs (Patel & Kleinman, 2009; Yu, 1997). A qualitative method has been chosen because it allows for first hand exploration of the experiences of Somali

immigrants and refugees adapting to life in the United States and could provide essential information that is currently not available through other research methods (Martin, 1994).

Definition of Terms

It is important that the reader is familiar with several terms used throughout this dissertation. To facilitate this understanding, following is a list of definitions used in this research study.

Somali community leaders are individuals who are chosen by the Somali communities to take responsibilities to improve the well-being of communities (Ebigbo, 1989). Leaders must be 18 years and older to be elected a leader of community (Ebigbo, 1989). They are supposed to serve people of their communities for 6 years and they can also be re-elected for another 6 years of duration. Their jobs are also to move forward and sustain strong communities and make changes in their lives (Foner, 1997). These community leaders are also chosen through election to contribute and they do not wait around for someone else to get the job done (Foner, 1997).

Culture refers to a combination of common socially transmitted patterns of behaviors, communication, beliefs, codes of ethics, and values that characterize a social group of people or a community. This accepted pattern of practice refers to their codes of conduct based on shared acceptable customs and values (Gallaido, 2006). Culture also implies the integrated patterns of human behavior that include thoughts, communications, action, customs, beliefs, values, institutions of racial, ethnic, and religious, or social groups (Ponterotto, 2010). Culture refers to rules, codes, beliefs and practices that orient,

educate, and motivate families and individuals toward a range of socially acceptable behaviors (Gallaido, 2006).

Race refers to a classification of humans into large and distinct populations or groups based on factors such as heritable phenotypic characteristics or geographic ancestry but also often influenced by and correlated with traits such as appearance, culture, ethnicity, and socioeconomic status (Isaacs & Benjamin, 1991). In the early 20th century, the term was often used in its biological sense, to denote genetically human populations, which would be marked by common phenotypic traits (Ponterotto et al., 2001).

Cultural norms are a set of patterns of behaviors and values considered to be typical of a specific group or population. They provide a specific standard and are effective in cross-cultural situations, congruent behaviors, and attitudes (Isaacs & Benjamin, 1991). The importance of racial/ethnic group identity is rooted in its presumed influence on the ways that individuals conduct their lives and interact with others. Members are believed to share an implicit understanding of what it means to be a member of a designated racial group but not all possible members of the group identify with cultural norms, nor do all members identify equally with those norms (Ponterotto, 2010).

Multicultural treatment is a practitioner's ability to adapt with the practice of cultural context of their patients. For the provider organization, elements of cultural competence include understanding of the patients' beliefs, values, behaviors, conducting of assessments, managing for their dynamics of differences, adapting with patients'

cultural knowledge, policies, structures, and treatment services presented patients and their communities Office of Minority Health, (OMH, 2006, p. 1). This also pertains to clinicians' opinions and knowledge when working with patients of different cultures, social class, race, or gender from their own (Ponterotto, 2010).

Assumptions

There are several assumptions, delimitations, and limitations associated with this research study.

I assumed that focus on experiences alone rather than empirical data would be sufficient to answer the research questions fully, because the interview results depend solely on the participants' perceptions of events. All results will include some subjectivity, and there is no verifiable guarantee of accuracy (Morrow, 2010). I also assumed that factors other than cultural competency among mental health care professionals affect the success of treatment for African immigrant and refugee patients.

I assumed that all mental health care professionals who have treated participants in the past are aware of the APA standards for ethics and diversity (ACA, 2001). Furthermore, I assumed that if people perceive themselves to be part of the African immigrant and refugee social, racial, and ethnic groups, they are likely to interact with the world according to the social context of these groups and would therefore be considered for inclusion in the study (Atkinson, 1983).

Scope and Delimitations

I depended on analysis of demographic data or its potential linkages to the experiences or outcomes of clients or their identified qualities. Although these factors

may influence the experiences of clients, demography is outside the bounds of the study because of the complexity of the arguments that link back to client success in therapy (Morrow, 2005). Because this project established only correlational results, no causation can be determined. In addition, all data on the nature of the cultural competency of mental health professionals who have treated the participants was limited to the participants' own perceptions and was not measured or collected for this study.

Limitations

The sample population reflected only eight Somali refugees and immigrants. I used this sample to demonstrate the congruence regarding the perceptions of Somali immigrant and refugee individuals about their experiences in mental health treatment. At the same time, limitations exist in defining individuals for this study based on their own identity rather than on defined characteristics. Because of disparities that relate to the terms *Somali immigrants and refugees*, the sample population referred to herein is from one geographic area (Morrow, 2005). This study was limited to one location, which is a midwestern state, so it may be limited in its ability to generalize for other populations. This investigation was limited to one instrument: the interview detailed in the appendix A. This means there may be factors that are not captured in the study.

Significance of the Study

Studying the experiences of the Somali immigrants and refugees in a midwestern state, offers them the opportunity to make their voices heard in a way that has not been possible before, outside of the community itself. Bringing out their voices could increase awareness among mental health service providers and facilitators of the need to be

resourceful and thoughtful when presenting mental health information to immigrant and refugee communities. This increased awareness could provide a step toward more effective mental health treatment, with the result being increased personal well-being, which could enhance family relationships, other interpersonal relationships, and the ability to contribute to communities and societies for immigrants and refugees around the globe.

Summary

Effective and appropriate mental health treatments are a major concern for minorities in the United States, especially Somali immigrants and refugees who have higher rates of depression, trauma, PTSD, and suicide than the U.S. population in general (Cole, 2008). My aim in this qualitative study was to explore the perceptions and experiences of Somali immigrants and refugees in mental health treatment and to determine how they contribute to patient perception of less effective treatment. This study will help both mental health practitioners and Somali immigrant and refugee patients.

In Chapter 2, will be reviewed to provide a historical and cultural context to Somali immigrant and refugee experiences coming to the United States. Somali immigrant and refugee cultural beliefs and practices that may have an effect on mental health treatment, and the cultural beliefs and practices within the U.S. mental health care system that present challenges when serving immigrants and refugees will also be reviewed.

Chapter 2: Literature Review

Introduction

In this chapter, I present a review and discussion of the literature on the challenges faced by Somali immigrants and refugees living in the United States, and the cultural norms that affect Somali patients' perceptions of Western-style mental health treatment.

Historical Background of the Conflict in Somalia

In January 1991, the president of Somalia fled the country leaving several clan-based guerrilla groups in charge. Civil war soon flared between warlords over the control of different regions (Menkhaus & Somalia, 2012). The combination of the horrendous drought, the bitter war, and the inhumane activities of Islamic militants drove almost half of the Somali population from their homeland, forcing them into refugee and immigrant status (Lindley, 2009). International aid was largely nonexistent due to the Al-Shabaab Islamic militants who controlled southern Somalia. Al-Shabaab is connected to al Qaeda and was largely responsible for prolonging the famine. Al-Shabaab militants blocked Western relief organizations from entering, stopped farmers from growing excess crops, and then claimed almost all the existing harvest as a form of taxation. Their rationale was the belief that Western relief organizations not only caused dependency on aid but stimulated the population to question the Islamic Sharia system they were intent on imposing (Menkhaus & Somalia, 2012). To further stress the population, in 1992 the worst drought for a century began and wreaked havoc and hardship on the residents of all countries situated on the Horn of Africa. It lasted several years (Potocky-Tripodi, 2002).

The resulting famine caused the deaths of more than 300,000 Somalis (Menkhaus & Somalia, 2012). Since 1991, Somalis began fleeing their country to escape the civil wars and famine. Many Somalis lost family members during the war, or were forced to live in refugee camps in neighboring countries. The stability of Somalia as continued to deteriorate, and it is estimated that more than 4 million people lost their lives because of war and hunger (Lindley, 2009). Somali immigrants and refugees were accepted into many countries. The current estimated number of Somali immigrants and refugees settled since 1991in the United States varies ranging from 35,760 to 150,000 in numbers (Federal Bureau of Investigation, 2013).

Experience of Being an Immigrant or Refugee in the United States

Somali immigrants and refugees face numerous problems as they try to settle down and raise their families in the United States. According to Darman et al. (2001), "Immigration itself is a stressor and may significantly contribute to adjustment" (p.401). Additional factors noted by the authority included factors associated with the stress that Somali immigrants and refugees face including discrimination, cultural shock, or conflicts.

Immigrant families arriving in their new country experience different levels of stress, depending on their country of origin, and ability to adapt to change (WHO, 2010). If the new country's culture is like the country of origin, the pressures of adapting may not be severe, but when both cultures differ greatly, shock, confusion, and stress affect the new arrivals. Not only is each immigrant family as a unit affected, but significantly, the individual members may find their roles and positions altered drastically (Potocky-

Tripodi, 2002). Somali immigrants and refugees may experience sudden and unexpected changes in their social lives, especially losing their identities as a member of a majority group and becoming members of a "minority" in the United States (Nwadiora, 1996).

Potocky-Tripodi, (2002) noted, as refugees who fled a devastating war, Somali refugees and immigrants are extensively affected by the trauma caused by their experiences from the civil war in Somalia (Potocky-Tripodi, 2002). Somali immigrants and refugees in United States have some or all their families in Somalia or in refugee camps in Kenya or/and Ethiopia (WHO, 2011). This refugee facilities lack basic service like food, clean water and personal sanitations. (WHO, 2011). This study also revealed that after resettlements, Somali families are faced with the difficulties of culturally adapting to their new home country (WHO, 2010). Somali culture is different from U.S. culture, and this caused a great deal of acculturation problems. In addition, they must learn a new language and adapt to a climatic condition that many are unfamiliar with. This combination of pre-migration problems and post migration living difficulties makes their adaptation in United States difficult (WHO, 2011).

Another major issue for African immigrant families arriving in the United States is the difference related to gender roles, which is typical in most African cultures. If such a family is flexible and the members can adapt, they will adjust to the new dynamic. If this is not the case, Ben-David (1995) found that the mental health of the immigrant family members would be worse than that of American native-born citizens. Gender-role differentiation is a strong influence in the lives of Somali families because most Islamic countries have fixed rules for the behavior of every family member (Bahramitash, 2003).

Bahramitash (2003) also indicated how most Islamic culture groups, both men and women, are treated differently and lead separate social lives. Despite of significant roles, rights and obligations between Islamic men and women, the majority of Somalian Islamic men are still using Islamic religion to outline and give structures to portray women as inferior human beings that prevents them from progressing (Bara-Acal, 2008). For example, in many Muslim countries, Islamic men are a degree above Islamic women with regard to dress code, marriage, and divorce, and women are sexually property for their male owners, males have a right to be a polygamist, among other factors. However, many of these oppressive practices of Islamic laws and policies affect various stages of Muslim women's lives (Bara-Acal, 2008).

In addition, many of the female respondents and some of the male respondents are still worried about the influence of the family (Bahramitash & Roksana, 2003). This research finds that despite the importance of remittances on the livelihood of many Somali immigrants and refugees, it has caused some tension among family members because of the limited resources of the Somali immigrants and refugees in the diaspora in the United States (WHO, 2010). Somali immigrant and refugee families have lived most of their lives in the context of gender segregated families where men and women were allocated different roles. The growing economic independence of Somali immigrants, and refugee women and the loss of the network of relations the family had, exacerbated a gender role reversal where Somali immigrant and refugee men suddenly had to assume roles that were traditionally assigned to women (WHO, 2011). These roles reversals have caused conflicts between spouses because Somali men believe that their authority is

being challenged (Keyes, 2000). One other finding of the study is the challenge associated with new parenting styles the family had to adapt to. Somali children are also having difficulties with their parents because of peer pressure from their schools and through communication contacts with their peers outside their community, which have challenged Somali immigrant and refugee way of parenting (WHO, 2008). Somali immigrant and refugee parents also believe that their children are losing touch with their faith and spirituality or religious values and beliefs. Somali immigrant and refugee parents also believe that their rights to give orders to their children are decreasing and as such they are losing control over their children (Bureau, 2008).

Somali immigrants and refugees often face a variety of stressors. They may suffer from post-traumatic stress disorder (PTSD) isolation from their social groups from their homeland and prejudicial treatment based on being Muslim or wearing traditional clothing. Within their new environment, Somali Immigrants and refugees may have difficulties adjusting to western culture including use of acceptable disciplinary methods of children.

Somali immigrants and refugees often face a variety of stressors, including post-traumatic stress disorder (PTSD), being isolated. When individuals experience high levels of a variety of stressors, it impacts their families and can result in the breakup of families, isolation from cultural peers, suicidal thoughts, and substance abuse (Jenkins, 1988). Another stressor may derive from the need to meeting the demands imposed by family members in their homeland. For instance, Somali family members in their homeland often believe that their family members from United States must send money to support

those family members who remain in their homeland (Nwadiora, 1996). Most Somali immigrants and refugees have two to three jobs to be able to live with the economic situation in the United States and continue to help their family members financially back at their homeland (Nwadiora, 1996). The weight of family responsibilities can negatively impact their psychological lives, which can then contribute to domestic problems such as child abuse or neglect, and disagreements between different families (Children' Bureau, 2008).

Disagreements about cultural norms between adults and children are also very common in immigrant and refugee families (Children's Bureau, 2008). Potocky-Tripodi (2002) stated that "intergenerational conflicts are influenced by the social context of immigration more specifically; parental understanding of their culture of origin is conceptualized in terms of the cultural dynamics present at the time the family emigrated." (p. 303). Thus, with time their cultural standard in their countries of origin often become different although their cultural structure of references may not because of children's parents often impose upon them (Children's Burea, 2008) These experiences can cause children to hold resentment or disregard for parents or may lead to children to rebellion (Potocky-Tripodi, 2002).

Somali Culture, Practices, & Mental Health

In Somalia about 85% of the population is divided into two main tribes, the Samaal and Dir. The two main tribes and divided into smaller sub-groups of Somalis who speak with different dialects and with different cultural traditions. The remaining 15% of the population is made up of immigrants from neighboring African countries. Somali and

Arabic are the main official languages. Swahili is spoken in urban areas and is often used in business transactions. Other minority languages include Bantu, Bajuni, and Bravanese. Many Somalis are peasant farmers and nomads or cattle keepers (Layman, & Basnyat, 2003). Because of the tribal divisions present in Somalia, the Somali immigrants and refugees coming to the United States are not a homogenous group. There are major differences in their backgrounds, traditions, customs and experiences, which forced them to leave their homeland (Corrigan, 2004). However, there are some key aspects of Somali culture that can be described.

In Somalia, the concept of mental or behavioral health does not exist, and there are no mental health clinicians to whom Somalis would turn to for emotional or psychological support (Layman, & Basnyat, 2003). While mental health problems are certainly present, outward displays of mental illness are heavily stigmatized. Because of this stigma, Somali immigrant and refugee patients do not discuss their mental health issues, and people with health mental problems are often kept within their community or at home (Larson, & Corrigan, 2008; Darman, et. al, 2001). Typically, Somali immigrants and refugees prefer to get support from members of their own social group, rather than mental health professionals (Atkinson & Whitely, 1990). Horowitz (1998) stated that "among Somalis mental illness is often treated as a family matter and mental health care decisions are usually made in the context of how they may impact the Somali family."(p.451) Moreover Zhang, Snowden & Sue (1998) conclude that, "when Somali immigrants and refugees attempts to solve problems on their own or in the intimate circle of friends and family members fail, ethnic minorities, including Somalis, often seek help

from community figures such as preachers or spiritual healers."(p.241). Zhang, et al (1998) further explained that "only after the escalation of symptomatology will medical and mental health professionals be considered."(p.391).

It is not uncommon for racial and ethnic minorities to express psychological problems as physiological symptoms. In keeping with this, researchers have also found that Somali immigrants and refugees tend to express and describe their mental health problems in physical terms (Egibo & Iheaue, 1982; U.S. Surgeon General, 2000). Egibo and Iheaue (1982) reported that Somalis suffering from mental health problems described their sensations such as heaviness or heat in their heads or burning sensations whereas their American counterparts reported feeling worthless, lacking interest in their usual activities and contemplating suicide. Obviously, standard diagnoses applied to members of these different populations would produce very diverse results.

Medication

In Somalia, people use herbal medicine and traditional medical health practices for mental health and overall health treatment. For example, honey and haba soda (derived from the roots of a tree) are used as preventative health measures. When Somali immigrants and refugees come to the United States, they continue these practices, and are more likely to use herbal and traditional medicines as opposed to than pharmaceuticals. Somali immigrant and refugee patients also may not be willing to take their medication if they do not see the benefit of medicine immediately. An additional deterrent from medication compliance are the complications from side effects.

Cooper et al. (2009) reported that patients of different cultural or ethnic backgrounds are affected differently by various kinds of psychotropic medications that are prescribed (Cooper et al., 2009). This factor is often not taken into consideration during clinical practice because there is an assumption on the part of mental health care professionals that there are no physical differences between immigrant and refugee patients of ethnically different Somali backgrounds (U.S. Bureau of the Census, 2011; Wright and Leung, 2010).

According to the WHO (2008) Somali immigrant and refugee patients are most likely to metabolize anti-psychotic medications more slowly than Americans who are born in the United States. This can result in a more intensive response to these medications by the latter group (U.S. Bureau of the Census, 2011). Somali immigrant and refugee patients with depression may also be more responsive to the effect of tricyclic antidepressants, which may be related to significant ethnic differences in pharmacokinetics and absorption rates with respect to the use of tricyclic antidepressants (Gonzalez, 2010). Somali immigrant and refugee patients are often treated with the same dosages that are commonly used for Americans who are born in the United States despite this pharmacokinetic or pharmacodynamics variability efficacy (U.S. Bureau of the Census, 2011). Wright and Leung (2010) found that Somali immigrant and refugee patients who have received anti-psychotic prescriptions in the past are more likely to be hospitalized and treated with higher dosages of medications. Herbck, (2004) found that Somali immigrants and refugee patients who have bipolar disorder are more likely to be labeled with schizophrenia, or given a different diagnosis.

Religious Faith

Somali immigrants and refugees often deal with mental health problems through their religious faith because they believe in their religion as a cure for mental illness (Lewis, 2002). For some Somali immigrants and refugees, reading the Qur'an and prayer is used as their sole treatment. Others may believe their faith is part of the healing process and may read the Qur'an prior to treatment to improve the outcomes. In Somalia, it is common for community leaders to talk about faith as part of the healing process, and doctors who are Muslim may discuss the role of Islam in healing with their patients as well.

Many Somalis also believe they need to have sufficient faith for treatment to work. For example, community leaders may counsel patients to pray and visit the mosque, but if the patient is not getting better, they may then direct him or her to a medical doctor. Somalis also believe that whatever experience they face is the will of Allah and as such they should not be questioned (Darman et al., 2001).

Although the United States mental health care system does not explicitly recognize the role of faith in healing, mental health providers may find it easier to talk about other methods of treatment of Somali immigrants and refugee patients after first acknowledging the role that faith plays in the Somali immigrant and refugee community view. (Kessler, Chiu &Walters, 2005). As described in the Diagnostic and Statistical Manual- IV (DSM-IV), humans use faith and spirituality or religious perspectives to examine their roles in social and cultural processes. In contrast to many purely psychological perspectives that focus on human cognition and behavior at the individual

level, sociocultural psychological theories use the interaction between individuals and their cultural practices, and spiritual beliefs as the fundamental unit of analysis (DSM-IV, 2005). This notion of activity offers a unit of analysis that affords an understanding of the complex intertwining of the individual and the culture in development (p.301). Therefore, in the practical, clinical context of cultural psychology, it is necessary to recognize the role of social engagements such as faith, spirituality or religious beliefs, as well as other shared interactions in the development of a personal sense of identity in mental health treatment (APA, 2013).

Provider Perceptions and Challenges to Providing Effective Mental Health Treatment

Limited research has been done on the mental health problems of Somali immigrants and refugees who live in the United States and abroad. It is therefore not surprising that there are many challenges to providing effective mental health treatment for Somali immigrant and refugee patients.

Practitioners lack awareness of Somali culture. Many mental health practitioners in the United States are not familiar with the cultural background and beliefs of Somali patients and as a result, the effectiveness of the treatment is compromised. Most Western mental health professionals are not fully aware of the conditions that are characteristic of some African and indigenous peoples relating to mental health issues. For example, severe stigma is often associated with mental health and even problems like deafness. The condition may be viewed as resulting from religious or supernatural forces. Somali patients may also have previously experienced indigenous health treatment. The

solution appears to be obvious; greater knowledge of Somali patients' experiences, beliefs, hardships and culture should create improved communication between patients and practitioners and increase the probability of successful treatment.

Biomedical approach may not meet all needs. Mental illness definitions in the United States focus on the biomedical approach to problem-solving. This approach is based on questioning, and physical or lab examinations, and is not oriented toward the whole body or whole health (APA, 1994). It does not consider the concept of "soul sickness" that is prevalent in other cultures. When patients fail to meet these expectations, the result may be inadequate service, and prejudicial treatment for ethnic minorities (Zarrehparvar, 2014). Jahn (2001) also found ethnic minorities in United States and around the globe are often categorized as "problematic patients" (p.80). WHO mental health surveys (2004) assert that "patients did not know the rules and brought other traditions and ways of thinking into the regulated work of the hospital." (P.201). Due to language differences, ethnic minorities may face longer waiting times for care, while staff wait for a translator to become available, and even with a translator, patients may not be able to accurately convey their needs (John, 2001). Frustrations about delayed or poor-quality treatment have been expressed by patients of different cultural backgrounds (Haney-Lopez, 2011). Based on the findings from Jahn's study, Roland (2002) suggested that the health care system has also failed registered nurses, as they are inadequately prepared to help patients from different cultural background. Nurses and other health providers may be left feeling frustrated and confused, as they are not able to provide adequate treatment (Ramsden, 1999).

Impact of social stereotypes on patient-practitioner relationship. In effective mental health treatment, the practitioner and patient relationship plays a central role. For individuals, not in the dominant white, American population, cultural connection between themselves and their provider is also essential. The foundation for this need for a cultural connection between practitioners and patients was noted as early as the 1970's in scholarly research, when critical language and cultural theory began to inform the psychological literature (Cole, 1969). Stark and Trisha (2003) were among researchers who examined the self-fulfilling influences of social stereotypes on social interaction in the form of dyads, such as practitioner-client dyads. In their study Stark and Trish (2003), demonstrated that dyads could fortify dormant forms of social controls through the introduction of stereotypes in the psychological field. Their theory is that "a perceiver's actions based upon stereotype-generated attributions about a specific target individual may cause the behavior of that individual to confirm the perceiver's initially erroneous attributions" (Snyder et al., 1977, p. 341) which can, in due course, affect the patient's understanding of his or her personal values as well as his or her self-identity.

Communication b**arriers**, Language barriers and cultural differences in intercultural communication can create "anxiety, assuming similarity instead of difference, ethnocentrism, prejudice, nonverbal misinterpretations and specific culture and language challenges" (Cooper et al., 2009, p. 901). There may also be fundamental communication differences between practitioners who are from one culture speaking one language with a patient from another culture speaking a different language. Kanagawa (2001) found that although there were language barriers and cultural differences

regarding how they presented themselves, both groups changed their self-identity when in a social situation. This means that there is the potential for patients to shift their responses in a multicultural treatment environment, which presents further challenges for those patients who may not have the ability to communicate their true feelings in their own languages and with their own cultural beliefs. In other words, even if there is no evidence of stereotyping or prejudice, multicultural treatment such as counseling may not produce the kind of results needed by African immigrant and refugee patients in a mental health care environment (Cooper et al., 2009).

For the United States mental health care system, addressing the needs of Somali immigrants and refugees presents a significant challenge. Mental health practitioners are placed at the front line to deal with the complex mental conditions of Somali refugees and immigrants for which they have no training and lack adequate sensitivity. As a result, Somali immigrant and refugee populations often do not receive proper or effective treatment and the ongoing care needed for their general well-being (O'Fallon & Dearry, 2001). The current practices and problems indicate that Somali immigrants and refugee patients leave the hospital visit confused, possibly misdiagnosed, with little confidence in the care provided and the medical system in general. As a result, language and cultural problems cause frustrations around access to mental health providers. Practitioners are unable to produce proper treatments as they lack specialized skills to deal with the language and cultural barriers (O'Fallon & Dearry, 2001). O'Fallon & Dearry, (2001) also emphasized that "immigrant and refugee patients can have a hard time understanding

medical correspondence, whether it is over the phone, on paper (e.g., children's vaccination records, or verbal directions given in the doctor's office." (p.305).

Cultural sensitivity. In addition, some advocates have also pointed out lack of cultural sensitivity from clinicians can be obstacles to seeking mental health treatment among Somali immigrants and refugees. Cooper et.al (2009) documented that lack of knowledge within physicians' staffs about Somali immigrants' and refugees' culture, history, or values can jeopardize mental health treatment. According to a communication with one of the community leaders in Minneapolis, "most providers are still unprepared to deal effectively (with any cultural sensitivity) with the community" (Mohamd, 2012, p.625. Somali immigrants and refugees have different cultural conceptions of mental illness, its causes, and appropriate treatment.

Somali immigrants and refugees do not understand the U.S. healthcare system. Somali immigrants and refugees do not trust the United States mental healthcare system because they are not familiar with how mental health treatment services which are being provided in United States compared to their mental health treatment back at home country in Somalia (Idemudia, 1995). They recognize that the United States mental health care system is not well oriented towards building relationships with their group. In addition, if one Somali patient receives poor care from hospital services rumors and bad news will be known throughout the whole of Somali community.

Cultural beliefs about mental illness. Somali people believe that mental illness or disasters are brought about by discord or wrongdoing, such as lack of faith in their

god, a person bewitched, or a person is being possessed by angered spirits; even accidents are believed to be under divine control (Mohamd, 2012). Other cultural concerns for Somali people include religious and gender norms, which do not allow women to be treated by male mental health providers.

O'Fallon and Dearry (2001) emphasized that "some immigrants and refugees also have expectations about health care providers that are at odds with the American system" (p. 739). O'Fallon and Dearry (2001) continued to say that "many African immigrants and refugees indicate that they prefer a provider who shares their background, while women from some cultures particularly the Somali and Arab women in the focus groups prefer to visit only another female provider, and yet this rarely happens" (p. 243). Cooper, et.al (2009) also mentioned "many African immigrants and refugees also expect to be cared for by a doctor and dislike the widespread use of nurses in the U.S. health system" (p 376). Williams (2009) described the response of Somali immigrants and refugees, who recalled a visit to a local emergency room where she felt insulted when treated by the nurse instead of a doctor. In such cases when clinicians do not understand effectively their clients' cultural expectations and preferences, it creates mistrust and suspicious feelings among the Somali patients vis-à-vis mental health professionals (Karliner, Acobs, Chen & Mutha, 2007). Heitritter (1999) conducted a study with 68 Somali immigrants receiving treatment at a hospital. They found that approximately 45% of the participants in the study reported that language barriers in health care services or settings interfered with their treatment. Of the studies conducted on this issue, none have investigated the specific experiences of Somali immigrants and

refugees seeking mental health treatment. The purpose of this study was to gather information to further explore experiences of Somali immigrants and refugees and to better understand why this population drops out of treatment at high rates.

Somali immigrants and refugee patients often receive support from family members, family friends, and family clergies who serve them as important sources of help with their mental health problems and other problems (The Colorado Trust, 2002). These members of the Somali community who provide cultural and social supports do not have the same level of training as western clinicians and mental health providers. Thus, if Somali immigrants and refugees rely solely on members of their community, they may be at risk of receiving inadequate mental health treatment (Carlin, 1990).

Challenges of using IQ testing. Somali immigrants and refugees may be exposed to clinicians using standardized, norm-referenced assessments during the resettlement process as they enter the United States or during initial visits for mental health treatment. There are several significant concerns related to the use of IQ tests with patients who are not native-English speakers, who come from very different cultural backgrounds, compared to the individuals in the normative samples used to create these tools and the creators themselves (Balsa & McGuire & Meredith, 2005). For IQ tests, some of the assessments used in clinical practice have not been updated for many years and have not been translated into additional languages (Ahearn, 2000; Marsella & Kameoka 1989; Tilbury & Rapley, 2004). Consequently, assessment results for a patient who is not a native English speaker may not be valid. The APA (2011) has indicated the practice of

assessing individuals in their non-native language is problematic. It is still questionable or unclear whether African refugees and immigrants can be understood using diagnostic screening instruments designed according to native English-speaking American models. The regular instruments being used for assessing refugees and immigrants before they are put in resettlement camps are IQ tests, which were developed using populations of individuals who were born in the United States and are native English speakers (Ahearn, 2000).

There are also challenges associated with use of the IQ tests in diagnosing and planning treatment for Somali immigrants and refugees. While the intent of these instruments is to measure the existence of mental health disorders, the results may not be accurate for Somali immigrants and refugees (Ahearn, 2000; Marsella & Kameoka 1989; Tilbury & Rapley, 2004).

Mental Health Needs among African Refugees and Immigrants in the United States

Somali immigrant and refugee patients need more personalized service within a mental health environment and mental health professionals are simply unable to provide that kind of individualized service (Cooper et al., 2009). Clinical observations expanded upon the findings in Cooper et al.'s (2009) study. For example, Somali immigrant and refugee patients are less likely to focus on problem solving in a mental health care setting, and instead are likely to benefit from the development of a more interpersonal relationship between themselves and their mental health professionals within their communities (Cooper et al., 2009). Similar findings have been evident from studying

Somali immigrants and refugee patients' experience, where an impersonal and focused clinical approach to care is likely not to be accepted (Cooper et al., 2009). Much of the success of a personalized therapeutic approach among these racial and ethnic groups can be traced back to the ability of the mental health professionals to focus on communication and listening, rather than instruction (Ridley & Kanitz, 2010; Rogoff, 2011; Enberg, 2010).

An inability of Somali immigrant and refugee patients to trust their mental health professionals can be linked back to endemic experiences of racism and stereotyping (Ridley & Kanitz, 2010), which means that the lack of congruency between mental health patients and clinicians can be tied to patients' perceptions of race and culture, as well as the mental health professionals' perceptions of these issues. An individual's experiences of mental health care disparities may exacerbate the differences between the patient and the mental health professionals, because many of the psychosocial norms expected of Somali immigrant and refugee patients have been defined by the mental health profession's social power context (Ridley & Kanitz, 2010). One Somali immigrant and refugee patient responded in a recent study, "most doctors are arrogant, stuck-up, self-centered and have attitudes of wanting to be above their patients" (Cooper et al., 2009, p. 251). This opinion demonstrates there is a fundamental challenge between mental health professionals and their patients who feel it is the responsibly of the mental health professionals alone to adjust cultural normative positions (William, 2009).

Coleman (2010) suggested that the identities of Somali immigrant and refugee patients are strongly influenced by their personal and social perceptions of their

experiences of mental health disparities and oppression. Therefore, there is a need for them to produce systemic control in an environment where their personal values and self-perception may be at risk due to mental health disparities (Montalvo, 2009). The psychological development of individuals in care is dependent on their ability to achieve their own personal goals in alignment with their self-concept, and this may not be possible in environments where racial experiences are not considered (Cooper et al., 2009). As a result, it may not be possible in some instances for Somali immigrant and refugee patients to benefit from mental health care which is not supplied by race or ethnic-concordant mental health professionals (Cooper et al., 2009). At the same time, disparities may exist in medical and mental health environments when attitudes about Somali immigrant and refugee patients are expressed by mental health professionals in ways that are not open and honest, so it is possible to create a negative way of thinking about individuals' differences in terms of language barriers and cultural differences even if it is not explicitly pronounced (Williams, 2009).

Political and Cultural Power Structures and Mental Health Treatment

Even before refugees and immigrants encounter the mental health system, there are significant disparities between themselves and the general population. After refugees and immigrants' resettlement in their host counties they continue to be vulnerable, facing marginalization, discrimination, and social isolation due to language barriers, cultural differences and lack of skills due to educational standards necessary for their employment (Lipson et al., 1997). Immigrants and refugees also face marginalization, discrimination, and social isolation due to their minority status, lack of language and educational skills

necessary for employment (Lipson et al., 1997). The disparities that exist within American society in general continue to be a major problem when individuals seek mental health treatment.

Williams (2009) argued that problems may exist in medical and mental health environments when attitudes about Somali immigrant and refugee patients are expressed by mental health professionals in ways that are not open and honest, so it is possible to create a negative way of thinking about individuals' differences in terms of language barriers and cultural differences even if it is not explicitly pronounced. The challenge in addressing mental health disparities is that they are fundamentally hidden, and often even occurs when individuals in positions of power and control are aware of its existence and are making no effort to counteract stereotyping that creates these disparities (Sommers, 2006). Sommers (2006) also explained that in the social context of mental health disparities there is a great deal of psychological power in group dynamics, which is why mental health problems exist even though people know they are wrong, do not want to participate in them, but make no effort to improve them.

The experience of mental health problems in a mental health care environment often goes deeper than the psychological experience of the patients (Montalvo, 2009). As noted by Greene (2005 p 903), the politicization of focused acts of ethnocentric problems allows people in their communities to form codes of behavior which, in their exclusion of Somali immigrants and refugee patients can enable specific socio-economic objectives (Blauner, 1994). These concepts have likely become intertwined and intensified through a mixture of growing racialization and conservative public policies enacted in the wake

of 9/11 (Greene, 2005). While Somali immigrants and refugees have historically been the most at risk for mental health disparities, Lacayo (2010 p 602) noted that 23% of Americans now believe that Somali immigrant and refugee patients are the highest discriminated against group in mental health disparities in the United States now and are subject to cultural policing in almost all their social activities.

As Romero (2007) described this challenge from a critical mental health disparities theory perspective, there is a link between assimilation, Americanisms, and power tactics, which can override the social experiences of immigrant and refugee patients, including social experiences in the health care system. Somali immigrants and refugees face an inherent risk, rather than simply a perceived risk, in Somali immigrants and refugees receiving care from native English speaking American people who are part of the endemic power structure. As Romero wrote (2007, p. 977) "focusing on assimilation not only conceals American citizen privilege; it also frames research questions away from examining mental health disparities, economic and political privilege among Americans, ethnic, and native and foreign-born groups of Somali immigrants and refugees." This means there is a lack of focus given to the fact that there are inherent power imbalances between immigrants and refugees from Somalia and American individuals on a policy level which can have an impact on the ability of immigrants from Somalia to ensure that they are protected both socially and psychologically over the long term (Romero, 2007). These challenges need to be considered in developing a socially viable response to the fears of Somali refugee and

immigrant patients with respect to multicultural mental health care (Greene, 2005; Romero, 2007).

Evidence for Potential Effective Treatments

APA (2013) published a report on working with immigrant-origin clients. The report provided guidelines and best practices for effective mental health treatment and services among refugee and immigrant patients. When conducting client assessments, clinicians should use culturally sensitive assessments and interviews, along with a comprehensive approach. When providing services, clinicians should use an ecological perspective, provide culturally competent treatment, partner with community-based organizations to provide services, and use evidence-based practices (APA, 2013).

There is research evidence to suggest some mental health treatment strategies are appropriate and effective for treatment of patients from African countries. Cognitive behavioral therapies have proven to be effective especially in treating symptoms of depression and anxiety in the general population (Surgeon General 2000). Egli (1991) found them to be effective for treating African immigrants and refugees because they, "use a targeted approach to symptoms, which are active and directive to address concrete aspects of life based upon
mind-body holism, more culturally neutral and responsive to individual needs, less language-bound, than insight-oriented therapy." (p. 554).

Several professionals have identified general principles for working with African patients. Potocky-Tripodi (2002) recommended therapists employ the mind-body link to explain the grounds for using psychotherapy. As stated previously, many African patients

describe their symptoms of mental suffering by using physical terminology. Providers should focus on the symptoms rather than talking about "mental health (Bayer & Peay, 1997). Nwadiora (1996) listed features to establish quality relationships between patients and therapists. Self-disclosure by an African patient is more likely if the therapist is active and dignified. Similarly, the patient's family life is important and the therapist should show genuine interest in any children in the family, their progress and some of the family's history before migration and details of their settlement in the United States.

Another important practice researchers have found that is successful for treating mental health needs among Somali immigrants and refugees is Community-Based Participatory Action Research (CBPAR) (Bhugra, 2004). The CBPAR method involves community leaders collaborating with mental health workers to improve the health of a community. Somali community leaders work to educate mental health professionals about the unique needs of their community, and at the same time educate community members about mental health treatment. CBPAR is also a research approach designed to facilitate trust with Somali immigrants and refugee communities, because they are active and participate in all phases of the research process. By using this approach, mental health professionals gain important research knowledge and experience, to further benefit Somali immigrants and refugee communities (Goza, 2007). Outcomes in terms of successful mental health treatment for Somali immigrants and refugees, and quality of research findings indicate that the collaborative approach utilized in CBPAR is very effective for this population (Bhugra, 2004).

Methods of Addressing Cultural and Social Disconnects in Mental Health Care

Cultural competency is an essential aspect of providing effective healthcare. With regards to providing mental healthcare the American Psychological Association are ethically obligated to ensure their own competence as they have official power to make legal decisions and judgments. For example, clinicians must remain sensitive to cultural in those they serve, challenge personal biases and continually work to update knowledge, skills related to diverse groups and range of individuals variation within those groups (APA, 2013). Given the many challenges in providing multicultural mental health care to African refugee and immigrant patients in the United States, it is helpful that the literature provides suggestions on how these may be mitigated in clinical practice (Montalvo, 2009). All clinicians need to integrate cultural conceptions of patients' values, beliefs, family culture, language differences, and traditional history into clinical practice (Ponterotto, 2010). Even though many clinicians and counselors are not aware of the value of multiculturalism in practice, current research suggests that all clinicians and counselors need to be multi-culturally competent. To be so, clinicians and counselors must be able to recognize themselves as cultural and racial beings (Ponterotto, 2010). This will allow clinicians to ensure that they are able to provide services with a level of cultural encapsulation that will enrich their mental health service delivery through a culturally informed and culturally sensitive approach to care for mental health of immigrants and refugees from Somalia and other immigrants and refugees from other parts of the world in the United States (WHO, 2013).

Even when training has taken place so that clinicians are better equipped for developing multicultural and language competencies, such training alone does not guarantee that the disparities are eliminated (Coleman, 2010). This may be linked to the fact that there are very specific cultural markers in place within African refugee and immigrant communities which may not be able to be accessed by individual counselors without these specific racial or ethnic backgrounds (Coleman, 2010; Haney-Lopez, 2011; Ponterotto, 2010). Somali immigrant and refugee patients are likely to prefer clinicians who have a professional knowledge about the kinds of institutional barriers that may have an impact on their use of mental health services (King, 2007). Most Somali immigrant and refugee patients indicate that the proper social approach for the delivery of mental health care should be relaxed and show sympathy (Dana, 2005), with a lack of focus on social hierarchy (Haney-Lopez, 2011).

To overcome mental health treatment disparities a color-blind approach to therapy has been advocated in the past but has not proven to be particularly effective in meeting the needs of Somali immigrant and refugee patients (Burkard & Knox, 2004). To the contrary, Burkard and Knox found that racial color-blindness in the clinical practice of psychologists resulted in a lower level of empathy for mental health patients. This was true whether the patient indicated race as a psychological issue and was not dependent on racial phenotype (Hall & Maramba, 2001).

The APA (2011) reported a color-blind approach by clinicians can result in counselors assigning a higher level of personal blame and responsibility to Somali refugee and immigrant patients with respect to their psychological issues. Some of these

issues can be resolved with a greater level of racial consciousness on behalf of both the clinician and the patient (Stockdale, Lagomasino, Siddique, McGuire & Miranda, 2008). This is demonstrated in practice when racial consciousness about practitioners and Somali immigrant and refugee patients is the same for both groups, but contradictory attitudes can have negative effects on the outcomes of patients (Pontertto, 2010). Along those same lines, a progressive therapeutic relationship, namely that which is present when the patients are at least one stage more advanced in terms of cultural consciousness than the clinicians and patients' problems can lead to patient problems in identity in development over the short and the long term (Marin, 2010).

Summary

In this chapter, research and information about Somali history, culture, and challenges related to Somali immigrant and refugee patients' attitudes, provider's perceptions, and potential effective medications that may impact on mental health treatment were reviewed. This chapter also provided an analysis of culturally specific needs of Somali immigrants and refugees, as well as an assessment of the limitations and opportunities present in common approaches to multicultural treatment processes.

The review points to the significant cultural and language gaps that exist between Somalia and the U.S; lack of awareness among most western mental health professionals of the conditions that are characteristic of Somali immigrants and refugee patients relating mental health issues; and that Somali immigrants and refugees handle their mental health problems basing on their faith and supernatural beliefs. The review also indicated that effectiveness of diagnosis and treatment for mental health problems applied

to members of different populations with different mental health perception produce diversity results. However, it does not show explicitly to what extend and why Somali immigrant and refugee patients seeking mental health treatment in the US have a higher dropout rate. Moreover, according to the studies reviewed there are significant concerns with the use of IQ tests and other assessments with patients, who come from very different cultural backgrounds (Hiliad, 1991).

This study was developed to address the gap in literature by exploring the "lived" experiences of Somali immigrants and refugees as they encounter the U.S. mental health care system with a clear understanding of disparities in the dropout rate during mental health treatment seeking. The Critical Race Theory (CRT) was utilized as a reference to consider the effects of racism inherent within the mental health care system on Somali immigrants and refugees. Researching the lived experiences will give Somali immigrants and refugees a stronger voice and may help them receive better mental health treatment in the United States and around the globe (Gong-Guy, & Cravens, & Patterson, 1991). In Chapter 3, the research questions, and proposed method to investigate the perceptions of Somali immigrants and refugees in mental health treatment and reasons for dropping out will be presented.

Chapter 3: Research Method

Introduction

My purpose in this study was to investigate the reasons for the mental health treatment disparities among Somali immigrants and refugees living in the United States, with emphasis on Somali immigrants and refugees who are settled in a midwestern state. I explored issues related to higher treatment dropout rates among Somali immigrants and refugees, which generated information about patient perceptions that provide an initial look at the reasons for dropping out. Although the information from this study could help provide higher mental health treatment to Somali immigrants and refugees, it will also help them access other mental health interventions. In this chapter, I provide the study design and rationale, date collection methods, data analyses strategies, and ethical confederations.

Research Questions

1. How do Somali immigrant and refugee patients describe their lived experience with and perception of mental health problems?
2. What are the participants' lived experiences with and perceptions of Somali immigrant and refugee patients regarding mental health treatment offered by mental health providers in United States?
3. How do Somali immigrants and refugees describe factors related to dropping out of mental health?

Research Design and Rationale

A qualitative phenomenological approach was adapted for this study with the use of face-to-face in-depth interviews. Patient perceptions of the effectiveness and appropriateness of mental health treatment problems was examined through detailed qualitative data collection and analysis. This approach was used to describe the existence and extent of mental health issues as well as pointing to factors that may cause or correlate these issues among the Somali immigrant and refugee community (Halfon & Hochstein, 2009). A qualitative phenomenological approach was appropriate for this study because of its emphasis on examining human lived experience and how they make sense of those experiences to explain their own conditions (Creswell, 2009). Among the distinct methods of inquiry in qualitative research, the phenomenological approach was deemed most suitable because such inquiry focuses on the participants' lived experiences (Ponterotto, 20001). Phenomenology allowed me to engage with the participants' perception of their lived experiences, which helped to give meaning and understanding to the phenomenon under investigation (Moerer-Urdahl & Creswell, 2004). Through interviews, Somali immigrant and refugee participants' experiences with and perceptions of clinicians were documented and explored.

Cooper et al. (2009) stated that a phenomenological approach to qualitative method research is more likely to be culturally sensitive to issues that may affect both clinical treatment and counseling process. This can lead to an increased level of personal feelings of security for a Somali immigrant and refugee patients, because it is more likely to be culturally sensitive to issues that may affect both clinical treatment and the

counseling process. Cooper et al. (2009) also reported that the qualitative methodology framework for phenomenological study is the best method available for research with this population, because it allows researchers to link together the ideas of participants who have shared the same experiences associated with the phenomenon (Morrow, 2005). In a phenomenological study, themes can be developed and explored, which can illustrate the experiences of participants in a way that informs the research literature in a more substantive way than through standard qualitative interviewing techniques (Williams, 1999). The overarching objective is to identify differences in the meaning of these themes with respect to what Somali immigrant and refugee patients from diverse groups prefer in their relationships with their mental health care provider (Banai, Shaver, & Mikulincer, 2005).

Among the other leading methods of inquiry in qualitative research, as defined by Creswell (2009), namely grounded theory formation, biography, ethnography, and case study approach, the phenomenological approach was identified as most applicable for the present study because this form of inquiry focuses on the participants' lived experiences, which are necessary to inform the existing literature, as noted by Comas-Diaz (2010). The grounded theory paradigm is aimed specifically at gathering data as a means of generating or discovering a theory. For these reasons, the phenomenological approach is assumed to be the most effective means of gathering the data needed to produce findings on lived experiences in mental health care for Somali immigrant and refugee patients (Ridley, & Kanit, 2010).

Role of the Researcher

In qualitative research, the participants are the primary foundation of the study and in this way, the researcher's role is to observe and report the outcomes of the study (Creswell, 2009). The credibility of research using qualitative methods depends on the competence, skills, and technique of the researcher. For this study, the main aim of the researcher is to conduct in-depth interviews using semi-structured interview questions to help understand the experiences of Somali immigrants and refugees living in A midwestern state with respect to mental health treatment.

Githens (2007) explained that immersing oneself in the experiences relayed during in-depth interviews requires sharing the experience of the narrative with participants. Moustakas' (1994) epoché is a method that brackets a researcher's presupposed knowledge and belief systems to help one abstain from judgments, theories, and preconceived frameworks that would taint the self-reported data from participants. As the researcher is an African refugee male who fits all the criteria outlined in this phenomenological study, the researcher's own perception is that lack of cultural awareness among mental health professionals, including psychiatrists, has a significant impact on treatment for Somali immigrant and refugee patients. As a graduate student, the researcher has had the experience of helping to complete the intake process for patients with mental health needs in a hospital setting. As part of the process, the researcher completed standardized IQ and psychological assessments, and observed that the same process and assessments were used, regardless of the patient's native language

or culture. Therefore, the researcher has the perception that mental health processes are biased and not matched to the patient's language or cultural background.

With the researcher's potential preconceptions in mind, the epoché technique was started at the onset of research and sustained throughout the research. Therefore, the researcher approached the process by utilizing an aspect of epoché called reflective meditation. According to Moustakas (1994), "reflective meditation allows past and present preconceptions and knowledge regarding information obtained from the literature review and past presuppositions to repeatedly enter and leave the researcher's consciousness until a sense of closure is achieved. The final step of reflective meditation involves the lead researcher labeling, writing down, and reviewing the prejudgments that were obtained during the reflective mediation until the influence of prejudgments within his consciousness diminishes and is released" (p.241). The researcher engaged in a reflective meditation process prior to every interview. This involved researcher recording by writing a journal of preconceptions about appropriate mental health treatment for Somali immigrants and refugee patients, and biases that arose during previous interviews.

As the interviews explored issues that were culturally sensitive or difficult emotionally for the research subjects, culturally sensitive support was provided to participants through the interview. To maintain professional ethics, the researcher also used strategies to protect research subjects before, during and after the interviews. Prior to interviews, informed consent was obtained from potential research subjects. Subjects were informed that they could withdraw their consent at any time. The researcher also reviewed how the information would be used, and informed subjects that no personally

identifiable information would be shared. During the interview, the researcher used native language, empathy and allowed as many breaks as needed. If a subject had difficulty during interview they were reminded that they could discontinue or withdraw from this study without any penalty or withdraw any signed form. After the interview, the researcher reviewed how the all the forms or information that was shared would be summarized. After the interview, the researcher briefed with each subject. If the subject needed more time to process their feelings, this was allowed. Subjects were reminded that their personal information would be protected.

Methodology

Sample Size and Sample Selection

A sample of eight volunteer participants was selected for the study. Criterion sampling procedures were used to yield eight volunteers who self-identified as Somali immigrant and refugee mental health patients. Demographic information regarding age, gender, languages, cultural differences, ethnicity, and willingness to share mental health information was gathered to selecting participants.

There were several criteria that need to be met for inclusion or exclusion in this study. As already indicated in chapter one, potential study participants were between18 and 35 years of age, and identify as Somali immigrants or refugees. Potential participants were identified as members of an at- risk group struggling with physical, psychological, social and emotional behavioral problems. Although different immigrant and refugee groups have different degrees of exposure to mental health problems, this age range between, 18 to 35 years, often feel vulnerable, overwhelmed with trauma, and unable to

cope with emotional situations because of psychological stressors that can reactivate their memories associated with events they have lived through (WHO, 2013).

All eight selected participants were included in the study regardless of their gender, sex, language and cultural differences. As the researcher is fluent in the participants' native language, translators were not required; however, to increase participants' comfort level during the interview, a Somali community leader of the same gender attended the interview. The researcher met with male and female community leaders prior to interviews to inform them of the purpose of the study, reviewed interview procedures and informed consent (e.g. participants are free to not answer specific questions or to end the interview at any time).

Instrumentation and Data Collection Process

The primary instrument for this study is a qualitative interview guide, which has been created exclusively for this research process and is included in Appendix A. The interviews will entail twelve semi-structured questions only. Twelve key semi-structured questions were asked to begin the conversation and eight basic demographic questions. The semi structured questions were used, to begin the conversation and additional questions was followed if necessary to clarify participant's responses or prompt spontaneous description. Qualitative interview data collected were explored participants' experiences, opinions, feelings and personal information. In a phenomenological study, "the participants must be individuals who have all experienced the phenomenon being explored and can articulate their lived experiences" (Creswell, 2009, p 142). The semi-structured interviews produced first-person, expert, natural data from participants who

could provide information on their lived experiences of the phenomenon being studied, namely the kinds of negative cultural experiences which led them to drop out of mental health care.

Participants who volunteered to take part in the study were contacted to schedule convenient interview appointments. After permission was obtained, the participants were given any additional needed or requested information. While participants were told about the purpose of the study in advance, interview questions were not shared with them until the interview. Each participant was given an appointment for his or her interview time, which was scheduled for a one-hour period. The length of the interview was at least 45-60 minutes. Participants were given the information that a follow-up interview may be required to clarify any information so that triangulation can occur. The protocol was the same for each interview. Participants were asked a series of semi-structured, in- depth interview questions about their background, lived experience during their mental health treatment and subsequent perceptions about dropping out from mental health treatment. Changes to the questions being used for the interview occurred as the research progressed, to guarantee that the contributions of the participants accurately represented the needs of the research, as each individual may have a different way of spontaneously responding to questions.

The researcher used an audio recorder for the participant interviews. Recordings was submitted to a professional transcriptionist for transcribing each interview notes. The researcher also used audio analogue design with the sample of eight Somali immigrant and refugee patients to examine the possibilities of these processes. Although first names

may have been used in the interviews the transcriptionist did not receive any personal data about participants and was asked to sign a confidentiality consent form as well. Interview copies were presented back to the researcher in three forms: original audio recording, digital copy and transcribed hard copies of the interview notes. Given the research methodology, only verbalized cues or comments were included as raw data in the recording and transcription. Field notes were taken at the time of the interviews to ensure that all non-verbalized information was also captured. Having each interview transcribed verbatim and keeping detailed notes helped to establish descriptive validity for this study. In addition, to determine internal validity and ensure triangulation of the data, participant confirmation of the interview notes once they are transcribed helped the researcher to gain an in depth understanding of the participants.

As noted by Creswell (2009), how participants were chosen for a study may "help the researcher to generate or discover a theory or specific concepts within the theory" (p 209). Transcripts must be examined via a rational phenomenological framework (Churchill, 2006). Data were collected and analyzed concurrently, during as well as after the interviews. The data analysis was both empirical and phenomenological (Churchill, 2006), and is also one that has been vetted on a practical level by Robbins and Parlavecchio (2006).

Confidentiality of all participants was maintained because the researcher and the transcriptionist was the only ones who had access to the tapes, and the transcriptionist was asked to sign a confidentiality agreement that all information was handed over to the researcher and no copies of data will be accessible to anyone except the researcher at the

end of transcription. All digital recording was destroyed after transcription in the presence of the researcher and transcriptionist. was completed

To determine interpretative validity and ensure triangulation of the data, participant confirmation of the interview notes once they were transcribed helped the researcher to gain an in-depth understanding of the participants' lived experiences and their perceptions regarding their clinicians' lack of cultural awareness. Moustakas (1994) discussed methods to ensure participants feel their contributions are valued and that the interview accurately captured their experiences. Debriefing to clarify misconceptions during the interview and asking participants to review the transcripts of their interview for accuracy are two methods of Moustakas. For this study, each participant was asked if there were any corrections or more information that need to be added at the end of their interview. In addition, participants were given a copy of their interview once it was transcribed and asked to review for accuracy and make any corrections.

Transcripts were examined through a phenomenological framework. Data analysis of this research included a few distinct steps. These include: (a) reading the descriptions, (b) delineating meaning units, (c) organizing the meaning units, (d) seeing the meaning units psychologically, (e) situating structural descriptions, (f) identifying general themes, and (g) constructing a general situated structure. This provided for greater semi-structured interview questions and gathering of data. The interview questions were asked to clarify participants' responses. From this, a composite structural description and major themes were developed, drawing from the meanings and essences of the experience and representing the participant group.

The interview survey questionnaire consisted of survey questions. The researcher was significantly aware of any language difference and cultural difference and personal biases in relation to data interpretation and results were analyzed in-depth.

Data Analysis

The data analysis process for this research was made up of seven distinct steps. These included: (a) reading the descriptions, (b) delineating meaning units, (c) organizing the meaning units, (d) seeing the meaning units psychologically, (e) situating structural descriptions, (f) identifying general themes, and (g) constructing a general situated structure. What this means is that textual descriptions of each interview were developed, with verbatim examples from the transcribed interviews based on every participant's experiences and their transcription needs. The researcher followed the preferences of participants. From this, a composite structural description and major themes were developed, drawing on the meanings and essence of the experience, representing the participant group.

The development of categories and themes of information enabled the researcher to look for patterns within the data, and to gain an understanding of the phenomena under investigation. Themes that appeared to be common to most participants were identified and further interpreted and analyzed for their meaning. The final stage of examination pulled all the information together through synthesis. Once the themes were solidified, it was possible to draw final conclusions about the meaning of the data. These were compared to the original research questions and recommendations for clinical practice were made.

Ethical Considerations

Before starting, the researcher made sure to comply with and follow all ethical standard procedures to the ethical guidelines of American Psychological Association (APA) and Walden University Institutional Review Board (IRB). The confidentiality and anonymity processes of the interviews was explained to the participants and questions about the nature of the interview were answered. Consent forms were explained as well. Every participant was asked to sign informed consent documents and a letter, which included a guarantee of confidentiality and any additional information that may accompany this process. Participants were reminded that participation in this study is voluntary and anonymous outside of the interview room, and any decision to withdraw from the interview will have no penalty. Participants were provided with the contact information of a local counselor or health care agency in case some find that the process brings up feelings of depression or grief about past experiences. If a participant became overwhelmed and unable to manage the interview topic, the interview was terminated and the participant referred to a health care provider directly. Further, applicable laws governing mental health research were followed. Informed consent of participation (see Appendix B) was secured before collecting data through the interview survey questionnaire. Each participant involved in this study was alert, oriented, and legally able and capable of giving consent for participation.

A code number was assigned to each participant in the study. The code numbers were used on the demographic and interview questionnaire sheets (see Appendix B) to identify participants. The researcher maintains a confidential list that links the code

number to each participant. This was only seen by the researcher and was be destroyed upon completion of the data analysis.

Summary

This chapter outlined the methodological processes that were used to ensure that the desired information was collected. The data was used to discover the lived experiences of Somali immigrants and refugee mental health patients' in a midwestern state through phenomenological research. A qualitative phenomenological interview framework was determined as the most appropriate method to examine the research subject at hand. The considerations behind the sample of the chosen population, the data collection and analysis procedures, the study's use of instrumentation and its reliability and validity are described in this chapter. By conducting a series of in-depth interviews with Somali immigrant and refugee mental health patient status, the overarching objective of the study is to identify differences in what patients from these cultural groups prefer in a therapeutic relationship with their chosen mental health providers (Kirsh & Tate, 2009)

Chapter 4: Results

Introduction

My purpose in this study was to investigate the lived experience with mental health treatment in Somali immigrants and refugees living in the United States. Somalis who are settled in a midwestern state, were selected as the sample for this study. A qualitative research design was utilized for the study with the purpose of exploring the lived experiences of Somali immigrants and refugees, as those experiences pertained to their dropping out of treatment for their mental health problems. The study was designed to fill a critical gap in the research literature regarding mental health treatment for Somali immigrants and refugees and methods to improve quality of treatment and access. This study was also provided to support strategies and policy actions to reduce disparities in mental health treatment for immigrants and refugees in the United States and around the globe. The research questions for this study were:

1 How do Somali immigrant and refugee patients describe their lived experience with and perception of mental health problems?

2 What are the participants' lived experiences with and perceptions of Somali immigrant and refugee patients regarding mental health treatment offered by mental health providers in United States?

3 How do Somali immigrants and refugees describe factors related to dropping out of mental health?

In this chapter, I describe the participants' demographics regarding ages, region of birth, marital status, number of children, and how many years resettled in the United

States. A summary of how data was collected will follow. The results from the 12 interviews are then organized into eight major themes and detailed subthemes that compare the similarities and differences among these eight Somali refugees and immigrants' experiences. Finally, I summarize the results obtained from participant interviews based on the research questions.

Setting

The data were collected at Moslem Community Organization of a midwestern state, because it offered the familiarity and convenience required by the respondents' due to the sensitive nature of the cultural and religious issues being discussed. The interview sessions took place in a private conference room. Each interview lasted approximately 45 to 60 minutes.

Participants in this study were a bit hesitant in engaging themselves in the interviews and refused to consent to being recorded during the interview because of some gender, cultural and religious gaps between the researcher and the participants. Participants were able to overcome their initial hesitation because the interview questions were presented in a respectful manner and the researcher decided not to record them on tape or video.

Demographics

Demographic data were collected prior to the interview process to provide a description of the study participants, including inclusion criteria data (see appendix A for the sample demographic sheet). Eight respondents (five women and three men) were interviewed for the study, all of whom were Somali immigrants who formally consented

to participate. All participants were between 18 and 35 years old and reported a household annual income between $20,000 to 40,000. Due to the subject matter of experiences of mental health issues, I repeatedly stated that participation was voluntary and that participants could withdraw from the interview process at any time. I also highlighted the benefits of sharing one's story and the influence it has on their own health and health of their family, in addition to increasing the knowledge base for how mental health providers in meeting the needs of diverse refugee groups.

Age, duration of residence in United States, marital status, highest level of education obtained, and family income of participants are presented in Table 1. Regarding marital status, none of the participants were currently separated, widowed, or "other" (which could include common law relationships). With regard to household composition, almost all participants lived with someone, usually with their children and spouse or significant others. Almost all participants were independent immigrants and refugees. The age of the female participants ranged between 20 and 36 years of age, whereas the age of male participants ranged between 20 and 35 years of age. All the participants were married and had between one and eight children. The average number of years the female respondents had lived in the United States of America was 7 years, whereas the average number of years the male respondents had been in the United States was 17 years. All respondents had some level of formal education. 40% of female respondents had a high school education, another 40% had a diploma, whereas 20% had a university degree. Among the men, 33.3% had a high school education, 33.3% had a 2-year college diploma, and another 33.3% had a university degree. The female

respondents earned significantly more money than the male respondents. On average the female respondents earned 15,000 dollars annually compared with 14,000 dollars for the male respondents.

Table 1

Participant Demographics

ID	Age	Sex	Marital status	Children	Years in United States	Education	Annual income
1	20	female	Married	8	5	high school	$12,000
2	20	male	Married	5	13	high school	$16,000
3	21	female	Married	3	11	degree	$10,000
4	32	female	Married	1	8	diploma	$20,000
5	35	male	Married	8	5	degree	$12,000
6	36	female	Married	3	5	diploma	$15,000
7	23	female	Married	5	6	high school	$19,000
8	33	male	Married	5	32	diploma	$14,000

Data Collection

Participants were included into this study if they were Moslem Somali refugees or immigrants, living in a midwestern state, and of legal age and able to provide independent informed consent to participate in this research study, and could communicate in English or Swahili. Five females and three males were interviewed. Respondents were interviewed using a script, and their responses were both recorded using a digital audio recorder and written down into the interview scripts by the researcher. Interviews lasted between 45 and 60 minutes and detailed notes were taken by

the researcher during the interview process. To maintain confidentiality and anonymity, each participant was assigned a code by the investigator.

A change was made to the procedures for data collection, due to participant discomfort. In the research proposal, it was indicated that interviews would be both video and audio recorded, however, participants indicated they were unwilling to have the interview video recorded. Therefore, interview information was recorded on paper interview notes and with audio recording. Before starting, the researcher made sure to comply with and follow all ethical standard procedures to the ethical guidelines of American Psychological Association (APA) and Walden University Institutional Review Board (IRB). The confidentiality and anonymity processes of the interviews was explained to the participants and questions about the nature of the interview were answered. Consent forms were explained as well. Every participant was asked to sign informed consent documents and a letter, which includes a guarantee of confidentiality and any additional information that may accompany this process. Participants were reminded that participation in the study was voluntary and anonymous outside of the interview room, and any decision to withdraw from the interview would have no penalty to them. Participants were provided with the contact information of a local counselor or health care agency in case some find that the process brings up feelings of depression or grief about past experiences. If a participant became overwhelmed and unable to manage the interview topic, the interview was terminated and the participant referred to a health care provider directly. Further, applicable laws governing mental health research were followed. Informed consent of participation (see Appendix B) was secured before

collecting data through the interview survey questionnaire. Each participant involved in this study was alert, oriented, and legally able and capable of giving consent for participation.

A code number was assigned to each participant in the study. The code numbers were used on the demographic and interview questionnaire sheets (see Appendix B) to identify participants. The researcher maintains a confidential list that links the code number to each participant. This list will only be seen by the researcher and will be destroyed upon completion according to the law of the land.

Data Analysis

Prior to conducting interviews, the twelve interview questions were organized into three categories:

A: Perceptions about Mental Health Problems

B: Perceptions Regarding Mental Health Treatment

C: Factors Affecting Mental Health Treatment

Theme Identification

Emerging from the data analysis, the findings from this research consist of concepts, themes, and subcategories. The overarching concepts were: respondents' views on mental health issues`, mental health resources, and coping strategies. The researcher listened to the tape recordings over and over and taking out main ideas that fit into specific themes. Interviewees' responses to the twelve questions given during the interview process were coded into themes which included: 1) Respondents' thoughts on causes of mental illness; 2) Mental illness appraised as a threat; 3) Social/Environmental

resources; 4) Personal resources; 5) Cultural appraisal; 6) Response to self; 7) Taking care of my emotional social/spiritual self; 8) Taking care of the physical body.

As the researcher listened to the interviewees, self-directed interview questions were developed by the researcher to help individual participants explore and reflect upon their mental health experiences and how these experiences impacted on their day to day living. The data were reported by using descriptive phrases, analytic summaries, and/or themes from interviewee's comments. After patterns of data were identified, the researcher created another set of themes to identify patterns of the data that were similar in expression. Full transcripts of the interviews are in Appendix C.

Evidence of Trustworthiness

To ensure credibility of responses recorded by the interviewer, each participant was asked if there were any corrections or more information that need to be added at the end of the interview. Participants were also given a copy of their interview notes and asked to review for accuracy and make any corrections.

Results

A qualitative phenomenological research strategy was implemented for this study. The researcher developed three categories to guide the data collection and analysis, and from these three categories, thematic areas were developed using twelve questions in total. The categories developed included:

1. How do Somali immigrant and refugee patients describe their lived experience with and perception of mental health problems?
2. What are the participants' lived experiences with and perceptions of Somali

immigrant and refugee patients regarding mental health treatment offered by mental health providers in United States?

3. How do Somali immigrants and refugees describe factors related to dropping out of mental health?

Somali Immigrant and Refugee Patient Descriptions and Perceptions of Mental Health Problems

All the respondents viewed mental health problems in a negative way. Some of the respondents associated mental health with madness, being weird, having loose connections in the brain, being crazy and they thought this is not something that should be discussed in public because of their cultural approach to mental health in general. One respondent noted that people with mental health problems make her afraid, while one respondent thought of mental health problems as being demon possessed noting, "To me mental health problems are losing wires in your brain, being possessed by demons or possessed by the ancestors from Africa."

One of the overarching concepts that emerged as an issue was to clearly understand "what is mental health." Mental health had various meanings for the respondents. When asked, what does the term "mental health" mean to you, the themes that emerged were mental health appraised as a threat with the following subcategories: fear, mad, crazy, frozen brain mind. Causes of mental health sickness had the following subcategories: supernatural causes, stress-related, and negative thoughts.

Table 2

Perception About Mental Health Challenges

Gender	Respondent #	Theme
Female	1	"For me when I think or hear about mental health challenges, I often draw a conclusion those individuals have madness including being crazy, somebody may actually be afraid of challenges it may also be somebody the families or friends could be afraid of challenges because in my culture, such individuals you may definitely cannot go around gossiping or talking about this individual openly and freely.
Male	2	'I often feel an comfortable and kind of weird when I hear the "word" mental health challenges because In my culture, It is very rare. In my whole entire life, I have never thought of discussing mental health challenges with strangers. According to my culture, it is something which you cannot share with any stranger and you cannot think of mentioning to anybody because it is a very scary stuff'.
Female	3	"I think the mental health problems means to me like somebody who is mad or crazy or somebody whose brain is frozen. Because of serious stigma on mantel illness, I often get afraid when I hear about any topic being discussed openly during serious conversation. In our culture, we don't talk about it because it is considered one of the taboos in Somalia".
Female	4	"I think mental health challenges means fear including being crazy, madness, weird issues not to be discussed in public, and also being overload with a lot of negativities including psychiatric disorders, depression disorders and schizophrenia disorders."
Male	5	"I think that mental health problems for me it means the state of being in right mind and consciousness without any internal and external disturbance temporally or permanently".
Female	6	Mental health illness is I mean psychological mental health which, damage to the brain or related to psychology of individual due to over thinking. Personally, I really think of psychiatric, depression, and schi-zo-phre-nia. (stammering on the word) those diagnosis that you hear about every now and then on television shows, in commercials and magazines.
Female	7	"I think mental health problem means to me as state of being mad and losing touch with realities and having a frozen brain".
Male	8	To me mental health problems are losing wires in your brain, being possessed by demons or possessed by the ancestors from Africa.

Mental health challenges facing Somali immigrants and refugees. The mental health challenges faced by respondents varied tremendously. These included, but were not limited to, stress, anxiety, tension, post-traumatic stress disorder, culture shock, adjustment problems, depression, frustration, disappointment, and all these problems seemed to be worsened by the language barrier faced by the respondents. It seemed like they had difficulty expressing what they were felling for failure to find a corresponding English word to describe what they felt. Female respondent #6 stated that "Language issues is one of my barriers to utilization for mental healthcare services. For example, the service providers might misunderstand me, either because lack of the ability to express medical terms in English or because English language choices did not always convey the intended my meaning.

Table 3

Mental Health Challenges Facing Somali Refugees Living in the United States

Gender	Respondent #	Theme
Female	1	Some of the mental health I have been facing is that when mental health stressor including PTSD whereby my heart sometimes will feel like jumping out of my chest. Sometimes I feel like my heat is pumping to much or working too much which makes me react like a crazy person and it is like saying that everything is going to be all right, or my brain or mind will be able to snap so that I could calm down or be able to slow down. Sometimes I feel like my body becomes very tense.
Male	2	I have been facing the impact of civil war trauma including cultural challenges and language differences. Since I came in United States, I have been having problems of adjustment with racism including limited skills and holding jobs.

Female	3	My mental health problem is that I have adjusting challenges which increase the risk of developing my behavioral and mental health problems. For example, missing my siblings and other relatives in Africa. I sometimes find it very difficult to work because of intense symptoms and signs of depressions stems from my family demands and obligations.
Female	4	I have language barriers which is making me not to access mental health services with mental health providers. I also have pain in my brain because the devil is very busy hunting for my life. I also feel very weak and do not have any strength at all. I normally get very frustrated with mental health providers because when I am seeking for mental health treatment I hope to get better right away and if I do not get it, I feel very frustrated and disappointed. I normally seek for treatment with the hope that all my mental health challenges I have will go away.
Male	5	Because of the trauma that happened to us during the war, and language barrier, I am not able to receive the treatment for mental health condition. There was a day when I was overwhelmed up to the extent of hitting my head on the walls in order to releases my pain, but instead I started to crying like a two-year baby girl. I started asking myself the reason why I came to this country because of being frustrated with the way how mental health service systems works. I have been very frustrated because of my cultural beliefs and background and facing a lot of challenges with cultural beliefs whereby I get frustrated with how the system works
Female	6	Language issues is one of my biggest barriers to utilize for my mental healthcare services. For example, mental health providers often misunderstand me whenever I visit health care service, I think either because I am lacking all the abilities to express myself in English language or speak fluent English language because of my I never went to school here in America. Lack of communication accessing mental health services, including desires dealing with challenges is also one of my concerns which is the main problem. I would also say that understanding is practitioners is also my biggest challenges because of cultural differences and linguistic differences including living with the fear being stigmatized which has been my hindrances that I often hold me back from seeking mental health help.
Female	7	"Yes, when I came to United States, I had a dream and goals, but my dreams and goals changed because of my son's mental illness. However, back home in my country for example, if somebody is mentally challenged or have issues with mental disability you are not treated well because of communication barriers part which is the biggest challenges. I can say so because many of these challenges stem from discrimination and racism which often create tension, misunderstandings and confusion. I have also a problem struggling with socioeconomically specifically because I do not know English language including financial hardship and obligations.
Male	8	It was hard for me to deal with my challenges communication barriers and maintain my normal life in this country and everything as far as my goals are concern. Lack of communication support from mental health provider including misunderstanding which often makes me cry and lack of sleep.

Somali immigrants and refugees descriptions of the causes of mental health problems. This question explored probable perceived causes of mental health problems among the respondents. And similarly, here, perceived etiology of mental health problems varied tremendously. One respondent associated probable cause of mental illness to negativity and weakness of the mind. Another respondent thought mental illness runs in families but also result from a curse. Respondent five stated "wronging somebody and they curse you so you end up with mental problem"

The remaining respondents thought that mental health problems result from peer pressure to succeed in America in comparison to their peers who stayed back in Somalia. They also thought that a major cause of mental illness is because of unfulfilling work here in America which is so different to what they were doing when they were still in Somalia

Table 4

Perceived Causes of Mental Health Problems.

Gender	Respondent #	Theme
Female	1	"I think the main cause my frustration and stress which has taken a tall on me and I also think that some of the causes stem societal stigma which is the main challenges causing my mental breakdown and losing the focus of my goals and I also think that the environment is the factors which comes with low self-esteem and also lack of support from mental health service to help them with their emotionally.

Male	2	Honestly, I think my challenges stem from my brain because of handling my problems and others. I live with negative individuals whereby my brain often gives up especially when you have a weak mind. Language barriers is also a significant problem and lack of knowledge about United State mental health care system and on the other hand some of the United State doctors seem to lack knowledge of being sensitive to Somali immigrants and refugee patients.
Female	3	The United States doctors seem to have very little or minimal knowledge about common illness or diseases from Somalia which might affect immigrants and refugee after coming to the United States. Some doctors seem not to have the knowledge of Somali immigrants and refugee traditional mental health practices including patient's cultural influences and expectations regarding traditional doctors's role.
Female	4	In my own belief, I think mental health challenges is being caused by many issues such as too much stress, too thoughts, or too thinking whereby with some individuals many have weakness in her or his minds whereby when they experience problems they often fail to hold the issues and have mental health break down any more and let it go.
Male	5	I also believe that sometimes it is something to do with curse. When you do not treat people like your relatives with respect and dignity, they can curse you so that you can end up having mental illness. Sometimes mental illness is genetic challenges which runs in the families.
Female	6	For me to be honest with you, as a Somali immigrants and refugees we often get scared to visit psychologist because I our mind as Somali, we believe that when they prescribe for us medication will freeze our brain so that we may become very sick and ended up being mentally ill. Or they can use new medications on us as experiment. I remember somebody told me that sometimes back United State doctors used black people to find out their experiments whether the medication works or not.
Female	7	I feel that Somali immigrants and refugees are lacking cultural responsive to United States mental health care system because of the challenges of communication between mental health providers and Somali immigrants and refugee cultural binderies. On the other hand, the way we Somali carry ourselves by not providing full information because we do not trust strangers very well. We also come from cultures whereby we often expect doctors to know our mental challenges whenever we visit them, but here we are expected to tell doctors what your mental health status is.

Male	8	For me I think stigma is an impact contributing to the silence associated with mental health challenges such as stress which prevents many refugees and immigrants from seeking mental health services the deserve. I also think that stress of Life here in United States associated with medical bills with is very challenging. We have challenges of missing our family members living back in Somalia. Some of us need urgent mental health services in our communities, but things are very tough whereby even connecting individuals to mental health counseling is often very difficult due to lack of receptivity of those who need such support.

Relatives r**esponses to** p**articipants'** m**ental** h**ealth** p**roblems**. When asked the above question, three out of the eight respondents felt that their relatives stigmatized them after they found out about their mental health problem, another three out eight respondents felt that their relatives thought that they were being bewitched which led to the mental health problems. The remaining respondent said that their relatives did not care about their mental health problems. The respondent also mentioned about the confusion that arose when they sought mental health care and often being turned away either because of lack of insurance or finding that they have a huge bill during their several times of visiting emergence hospitals. Lack of cultural responsive mental health care is also very alarming.

Table 5

Relatives' Responses to Mental Health Problems of Participants

Gender	Respondent #	Theme
Female	1	"From families, religious leaders and my cultural leaders often get encourage which help me to progress in my goals and dreams as time goes by"
Male	2	"To the mosque because of lack health insurance"
Female	3	"To community leaders because of my cultural beliefs"
Female	4	"To family members because of my cultural back ground and beliefs"
Male	5	"To community center to get encouragement that helped me to progress well as time goes"
Female	6	"To hospital because I have the insurance"
Female	7	"To the hospital because I trust the mental health providers"
Male	8	"To cultural leaders because I trust in them"

Participants expressed frustration of adjusting to new communities and new cultural background and as a result, some of the refugees and immigrants believe that they are bewitched whereby they become worthless in their communities. As such it affects mental health services including jobs, housing, emotional isolation, basic cultural differences.

Perceptions of Somali Immigrant and Refugee Patients Regarding Mental Health Treatment Offered by Mental Health Providers in the United States.

Where participants sought mental health treatment. Majorities of the participants used informal coping mechanisms, in such a way that talking to their families and friends including religious leaders. All participants in this study come from Somali cultural backgrounds whereby families and community leaders are often being consulted

about any kind of mental health problem. For example, when people leave their home country to live in another country, their families left behind at home experience different kinds of stress because of their uncertain future and these issues often hinder refugees and immigrants from coping effectively in their new country, as they are often thinking about how to survive in their new country and solve problems back in their home country.

Table 6

Where Participants Seek Mental Health Treatment

Gender	Respondent #	Theme
Female	1	From families, religious leaders and my cultural leaders often get encourage which help me to progress in my goals and dreams as time goes by
Male	2	To the mosque because of lack health insurance
Female	3	To community leaders because of my cultural beliefs
Female	4	To family members because of my cultural back ground and beliefs
Male	5	To community center to get encouragement that helped me to progress well as time goes
Female	6	To hospital because I have the insurance
Female	7	To the hospital because I trust the mental health providers
Male	8	To cultural leaders because I trust in them

What worked for participants when they sought mental health treatment and how they described their experience in treatment. For all respondents interviewed, their faith and belief in something bigger than them, worked well for them in their dire time of need. This something was either belief in their God, prayer or family relations. Those who believed that their God helped them expressed issues with how this help was

offered, and this came out in the rituals practiced. The majorities of participants expressed their frustrations with the disconnect between their religious and cultural practices and those of providers. Respondent #2 stated "My prayers because Allah answers my prayers. I did not like the way they present themselves when praying

Table 7

What Worked for Participants When They Sought Mental Health Treatment and Descriptions of Their Experience in Treatment.

Gender	Respondent #	Theme
Female	1	My belief. I am a religious person. I did not like their routine, and their lack of social interaction
Male	2	My prayers because Allah answers my prayers. I did not like the way they present themselves when praying
Female	3	My strong family values because my family care about each other
Female	4	My family beliefs because my family believes in God
Male	5	My prayers because I have faith in my God.
Female	6	My religious belief strengthened my faith
Female	7	My religious background helped me to have confidence
Male	8	My cultural values helped me to think about the future not the past

Challenges Participants Described that led Them to Drop out of Mental Health Treatment

All the participants mentioned that mental health challenges were not a topic which is supposed to discussed openly with strangers or discussed during or carry on

serious conversations. Culturally mental health challenges, according to all participants are considered as very shameful issues, and participants prefer to discuss these challenges in secret ways to avoid stigma. This sentiment was reflected in many statements made by respondents and in the researcher's observations. Some participants who reported that they could not share their mental health challenges with strangers, made this decision because they feared being labelled as weak-minded individuals who have lost touch with their cultural beliefs. In addition, participants also characterized mental health illness as a sign of individuals weakness and whereby some them only seek for help their last resort.

Table 8

Challenges Which led to Participants Falling out of Treatment

Gender	Respondent #	Theme
Female	1	Because it is a long process
Male	2	In my culture, people do not discuss their mental health issues, and people with health mental problems are often kept within community or at home
Female	3	It is not uncommon for racial and ethnic minorities to express psychological problems as physiological symptoms.
Female	4	In my culture, people use herbal medicine and traditional medical health practices for mental health and overall health treatment
Male	5	Because my beliefs and faith are part of the healing process and reading the Qur'an prior to treatment as a way to improve the outcomes.
Female	6	Discouragement from family members
Female	7	Because of language barriers
Male	8	Because of believing in my faith as a healing process

Mental health resources participants accessed in the United States. Most respondents stated that they knew that they are able to access a counselor. One respondent was aware that they could access psychiatrists who know their language and culture because language issues is the major problem which often cause frustration waiting to access health care services. Respondents who thought about accessing government services stated that they feel more decimated because of their stigmatized faith and different culture as Muslim Somali refugees and immigrants. Sometimes we as Somali have some higher expectations about mental health care profession which are

odds within Western system because most mental health professions are still not well prepared to deal with effective cultural sensitivities within communities.

Table 9

Mental Health Resources Accessible by Participants

Gender	Respondent #	Theme
Female	1	I have seen a counsellor at the mosque
Male	2	I have seen a psychologist in a mental health facility
Female	3	I have seen a marriage counsellor
Female	4	I have seen a religious counsellor
Male	5	I have seen a family counsellor
Female	6	I have seen a psychiatrist
Female	7	I have seen a case worker
Male	8	I have seen a social worker

..... When participants determined their need to seek help and what kind of help. Most respondents described that when they developed distressful symptoms, they knew that it was time to seek help. The symptoms developed varied from depression, to hunger, psychological distress because of marital problems, to uncontrollable behavior in their children which produced psychological distress. The kind of help which was primarily sought by the respondents also varied from respondent to respondent. Most respondents primarily sought help from their community mosque, while at least two respondents sought professional help from a qualified counselor.

Table 10

When Participants Saw the Need to Seek Help and What Kind of Help?

Gender	Respondent #	Theme
Female	1	When I was depressed, I saw the Imam and talked to him about my issue.
Male	2	When I was homeless and our family had nowhere to live and nothing to eat, I went to the mosque to ask for help
Female	3	When I arrived as a refugee they directed me to the catholic shelter where I could find food, clothes and other basic needs
Female	4	When I had problems with my husband because he was cheating on me, I became stressed and my friends counselled me and directed me to seek professional help from the cultural leaders who would talk to my husband
Male	5	When my children became uncontrollable, I became stressed, and it got worse when the oldest run away from home. I had to report this to the community leader who intervened.
Female	6	When my child started using drugs, I went to the community counselor and he talked to my children about their unacceptable behavior and helped him join a rehabilitation program.
Female	7	When my mental health provider had a misunderstanding with me, because of my cultural background I went to the mosque
Male	8	I started gaining weight and became really sick with pressure.

How participants described their interactions with mental health providers.

Most respondents felt that their mental health provider was not sensitive to their cultural beliefs, or their refugee status, and therefore recommended that their mental health providers learn more about Somalia culture and treat refugees with respect. One respondent thought it would be a good idea to have a good interpreter available at these meetings. The respondents also expressed their frustration faced with difficulties of

adapting with new mental health service system including environment and cultures in the United States.

Table 11

Changes to Services or Providers Described by Participants

Gender	Respondent #	Theme
Female	1	They should be knowledgeable, about our cultural beliefs and should have skills to handle mental health issues for immigrants.
Male	2	They should be compassionate and respectful
Female	3	They should be patient and kind
Female	4	They should kind to us and visit us at home
Male	5	They should be respectful of our culture
Female	6	They should have a good interpreter and should be more accepting of immigrants
Female	7	They should have empathy and they should give us free services.
Male	8	They should understand the culture and the beliefs of immigrants.

Additional mental health resources participants were aware of in their community. While one respondent was not aware of any mental health services available to them in their community, the rest gave responses which included; church counseling programs, state mental health programs, and private counselors, traditional and cultural counseling.

Table 12

Mental Health Services Available to Participants in Their Communities

Gender	Respondent #	Theme
Female	1	I do not know
Male	2	Community Christian counselling
Female	3	State hospital services
Female	4	Hope After Rape, and Catholic Relief Services
Male	5	Christian church counsellors
Female	6	Private counsellors who advertise in the newspaper
Female	7	Case workers for the state
Male	8	Hospital counselors

Changes to services did participants described as being important.

Respondents believe that their mental health provider should be knowledgeable about their culture and their special status as refugees. They further think that their mental health provider should be kind, patient, compassionate, and empathetic. Respondent also think that providing enough information to immigrants and refugees especially health services in United States in regards to their legal rights as far as counseling is concerned.

Table 13

Recommendations for Mental Health Services.

Gender	Respondent #	Theme
Female	1	They should be knowledgeable, about our cultural beliefs and should have skills to handle mental health issues for immigrants
Male	2	They should be compassionate and respectful
Female	3	They should be patient and kind
Female	4	They should be kind to us and visit us at home
Male	5	They should be respectful of our culture
Female	6	They should have a good interpreter and should be more accepting of immigrants and refugees
Female	7	They should have empathy and they should give us free services
Male	8	They should understand the culture and the beliefs of immigrants and refugees

Respondents believe that language barriers including the cost of mental health care services, societal stigma because of civil war in Somali, and other issues of mental health professional lacking knowledge and awareness of different cultural issues of Somali immigrants and refugees including biasness, or inabilities to speak the patients' languages, and patients' fear of mistrusts of treatment they deserve for themselves.

Summary

The main aim of this study was to explore the perceptions of mental health treatment of Somali immigrants and refugees and examine reasons for higher treatment dropout rates among Somali immigrants and refugee for their emotional and psychological stress in United States. Somali immigrants and refugees in this study face

different challenges regarding their mental health and how to access mental health services including language barriers and being unfamiliar with available mental health services in place, beliefs and perceptions about mental health challenges and mental health treatments which are different from those of the United States or western treatment services (Whitley et al., 2006). The findings of this research study underscored the significance of different dimensions of Somali refugee and immigrant's mental health and cultural challenges.

The results above show that Somali immigrants and refugees face a variety of mental health challenges including; stress, anxiety, tension, post-traumatic stress disorder, culture shock, adjustment problems, depression, frustration, disappointment, and all these problems seemed to be worsened by the language barrier faced by the respondents, whose etiology according to the respondents is attributed to things such as; negativity, weak mindedness, genetics, curses, pressure of work, just to mention but a few. Whereas many of the respondents faced a lot of stigma because of their symptoms, they described a strong sense of community which involved consulting community leaders, family members and religious and spiritual leaders as a coping mechanism. Most respondents preferred this mechanism as a priority over consulting medical professionals simply because of some barriers they identified which included; language barrier, which made often made it impossible to communicate with health professionals in a way in which they could be understood by these health professionals. Some respondents felt that the health professionals were disrespectful to their culture and beliefs, often brushing them aside, and this was offensive. stress, anxiety, tension, post-traumatic stress disorder,

culture shock, adjustment problems, depression, frustration, disappointment, and all these problems seemed to be worsened by the language barrier faced by the respondents. In addition, there are many similarities of stories that the respondents motioned about their mental health challenges during the interview whereby most of them believe that barriers including the cost of mental health care services, societal stigma because of losing their beloved ones back in Somali during civil war, and the fragmented mental health services in their community.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this study, I explored the lived experiences of Somali immigrants and refugees related to mental health treatment and explored issues related to higher treatment dropout rates among Somali immigrants and refugee in the United States. However, various research studies among Somali immigrants and refugees are available through the lens of insufficient data is published regarding mental illness among Somali refugees. In trying to legitimize the findings of this study, I compared findings to existing published data related to immigrants' mental health and the reasons for poor adherence to treatment programs and the high rates of treatment dropout (Sorrell & Redmond, 2009. The APA defines *mental illness* as health conditions involving changes in thinking, emotion, or behavior or a combination of these, and associated with distress or problems functioning in social, work or family (Brown, Abe-Kim, & Barrio, 2003). Using this definition, the majority of respondents had difficulty correctly defining the term mental health illness, and the focus was centered on mental health treatment. Although the term *mental health illness* has a different definition to Somali communities, most participants considered mental health problems to be closely associated with psychiatric illness. The respondents associated mental ill-health with carrying a curse, being crazy, being mad, possessing evil spirit, having bad genetics, carrying a frozen brain, or being mad. Among Somalia immigrant and refugee community, mental health patients are often experience prejudice, are often feared, and rejected by other individuals in their community (Kakuma et al.,

2009). As noted in by Odejide, Oyewunmi, and Ohaeri (1989), irrespective of education status, people still believe in supernatural causes of mental ill health, and this normally affects the choice of mental health treatment Cole, 2008). Similar findings have come out of epidemiological research done in my country of origin, Uganda, where many traditional healers interviewed identified curses, evil spirits, and witchcraft as potential causes of mental illness (Ovuga, Boardman, & Oluka, 1999). Another study from Somalia showed that rural dwellers were more likely to attribute mental illness to supernatural causes compared with urban dwellers (Adewuya & Makanjuola (2008).

Interpretation of Findings

The household where patients with mental illness live, plays a major role in determining the patient's health seeking behavior of mental health patients and their understanding of the concept of mental health. Some respondents reported mental and physical health symptoms but did not report seeking any medical help to alleviate their concerns. Perhaps for these respondents, their individual beliefs about what is stressful enough to require professional mental health, influences their decision to seek this mental health services. Challenges such as lack of language appropriate services, a personal desire to champion one's own problems, the feeling of not being understood by health care providers, language barrier, and stigma may perhaps have an impact on mental health seeking behavior (Whitley et al., 2006). Strongly held cultural beliefs prevented respondents to discuss in detail about mental health stressors and these issues were avoided because of the stigma attached to being mentally ill and the culture that stigmatizes the mentally ill in the Somali community.

In Somali community, cultural roles are being considered as important topic because their culture has a strong bearing on their self-image and acceptance within their host communities. Any program claiming to be sensitive to the needs of immigrant and refugee clients should consider their individual social and cultural influences. Many traditional societies still rely on rudimentary means for treating mental and emotional ill health Onyemaechi, (2000). Healing is often being considered as a personal matter between mental health professionals and their patient in Western world or society whereas healing in Somalia is a mater which involves the whole entire community including community leaders and religious leaders (Fenta, & Hyman, & Noh, 2006). In addition, within community of Somali refugee and immigrant decent, mental health professionals are often being perceived as a process, which requires that patients must expose their business to strangers which is totally against their cultural beliefs (Priest, 1991). Sharing information regarding mental health issues is prohibited with strangers because it is against their cultural beliefs (Priests, 2008). This finding is consistent with the finding in the present study, as most participants stated they do not like sharing their personal life with strangers. In addition to Somali refugee and immigrant cultural background, they have their cultural beliefs that by enduring and overcoming mental health problems through actions of prides and strengths can contribute to their sensitive beliefs that to seek for help is a sign of weaknesses, as stated by some participants view that men should be strong and not show their emotions, cry or seek help which is viewed as a sign of weakness.

Research has shown us that stigma directed towards mental health is universal irrespective of the cultural group involved, western and nonwestern alike. In the United States of America, a study on black West Indian American women showed that respondents denied being depressed to avoid being shunned and stigmatized, or labeled as “crazy”, “insane”, “coo-coo” or “nuts” (Schreiber, et al, 1998). This result is consistent with the results from this study on Somali immigrants and refugees who described individual’s suffering from mental health problem including experiences of mental health stressors such as being ‘mad’, ‘being crazy’ and ‘being weird’. Respondents too were not only shunned but described as ‘can’t be trusted, should not be feared, and should be isolated’.

Participants revealed how availabilities of resources were the major challenges regarding recurring concept which emerged within the cluster of substantive themes, such as social/environmental resources, personal resources, and cultural appraisal. Deciding whether to take action on health concerns, and if so, how to take action, is influenced by an individual’s background and beliefs in conjunction with their positive and negative experiences with health care. New research has indicated the evidence that there is a differential pattern of use and response to mental health services among ethnic population group (Brown et al., 2003; Myers et al., 2002; Thompson, Bazile, & Akbar, 2004). There is also very limited visible or overt mental health challenges and thus there is a significant gap in utilization of mental health services. In the current study, only two participants sought the help of a counselor to handle their emotional stressors. Kirmayer et al. (2007) conducted a study in a midwestern state on the use of mental health care

services for psychological distress, with a random sampling of approximately 998 Somali immigrants and refugee and the study revealed that the rate of mental health services use for psychological distress was lower among Somali immigrants and refugee patients (6.8% compared to 16.8% for individuals who are born in United States. Conversely, the second major factor that dissuades mental health treatment- seeking is lack of adequate knowledge of mental illness and resources available in the community. In the present study, almost all participants stated they did not know where to go for mental health resources. At the societal level, culturally sensitive and specific mental health services prove the best approach towards positive mental health outcomes. Despite good intentions, services remain underused when formulated without a contextual understanding of the clients for whom they are intended (Newbold, 2005; Whitley et al., 2006). O'Mahony & Donnelly (2007) conducted a qualitative study which explored how contextual factors intersect with race, gender, and class to influence the way in which Somali immigrant and refugees seek help to manage their mental health problem. It also attempted to identify which interventions were most effective in meeting the mental health needs of Somali immigrant and refugees (Helman, 2011). The study found that barriers to mental health services include inefficient language skills, unfamiliarity of services, and low social economic status. This finding is consistent with the present study in which almost all respondents raised mental health services and language as major issues. Hellman (2011) concluded in the previous study that gender roles limit Somali immigrant and refugee's accessibility to mental health care, whereas in the present study

gender was not an issue. Healthcare providers need to recognize and facilitate the removal of structural barriers that immigrants face when seeking care (Helman, 2011).

Respondents in this study stated that when faced with stressful situations they reverted to using prayer and meditation as a means of overcoming stress. This concept of using spirituality to overcome stress is not new. A study by Van Olphen et al. (2003) revealed how spirituality can help to reduce depressive symptoms and positively impact one's overall health. One respondent stated that the peace that comes with being in the presence of brothers in religion removes stress and serves as a major support. This assertion is divergent from the western health beliefs which attribute the presence of illness to germ theory, paying very little or no attention at all to supernatural causes for disease all together), making it even more difficult for Somali immigrants and refugees suffering from mental health problems to seek help from qualified professionals (Venters, et al, 2011).

Cultural mistrust is another issue that most respondents dwell on when dealing with mental health issues. Some of the respondents believe that mental illness can be controlled with treatment and counseling. They were, however, ambivalent and apprehensive about the use of medication to control mental illness, mainly because of side effects. An overwhelming majority of respondents in this study, who had experienced mental and physical health symptoms, indicated that they had sought help from either social support (family, friends, roommates) or nobody. This pattern of low utilization of mental health services by African immigrants has been explained in various ways. Among Somalian societies, Jegede (2008) suggested that usual health-seeking

mental health problem is that the patient first seeks help from traditional sources (spiritual sources) and lastly from health professionals. Due to this general practice of using traditional and home remedies, Somalis may be more comfortable with this avenue and seek it out first, before consulting with mental health professionals. Furthermore, in most African communities, Somali immigrants and refugees are used to taking care of problems by being there for each other, and they seek assistance from religious/spiritual leaders and community elders, as opposed to doctors or therapists. In the study by Constantine et al., (2005), African international students expressed their skepticism of the usefulness of confessing their problems to strangers. A study conducted by Erickson and Al-Timimi (2001) on Arab immigrants showed that family is the center of their social environment and social organization, therefore, during an illness or crisis individuals may depend heavily on other family members for support and help in coping. This mental health problem was like that of participants in the current study. Hence, due to this interdependency and extensive family network, Arab Americans may tend to be reserved initially in dealing with individuals from outside their social network, particularly in seeking professional mental health services (Erickson, & Al-Timimi, 2009).

Limitations

This is a qualitative study and relies on voluntary participation of participants who self- identify themselves as Somali immigrants and refugees; hence the study captures only the experience of those who choose to participate in this study. The experience of those who choose not to participate might be very different. It should also be borne in mind that this is a small sample size which will reflect the experience of Somali

immigrants and refugees with particularly living in a midwestern state. Hence, findings cannot be generalized to the larger Somalian community. Another limitation was found in researcher presupposition. In an ideal world, the researcher would be able to remove himself from the data under study. However, due to real world conditions and the inability of anyone to totally remove themselves from the investigation, some bias could creep into the study (Kirmayer, 2012). Also, another limitation is that Somalia is a country with various cultures. This might not reflect the broader views of all Somalian in their respective country. Additionally, most of the respondents were from the Somali region. The method of recruitment may have influenced the reachability of the study to Somali immigrants and refugees from Somalia, especially if respondents' social networks drew from individuals from their own country of origin (Weerasinghe, & Mitchell, 2007).

Recommendations

There were eight Somali immigrants and refugee participants for this research study. Participants may have been having the capacity of using a different method of recruitment other than combining emails and phone calls. A larger number of Somali immigrants and refugees would have participated via other means of recruitments method such as recruiting both participants and their children to address participants-children relationship and their mental health status and dynamics. This research study did not offer participant's motivation and encouragement to participate in this study. Looking back and contemplating the past, it is possible that motivation and encouragements would have improved large numbers of participation in this research study (Porritt, 2009).

Future studies could also provide provided an analysis of culturally specific needs of Somali immigrants and refugees, as well as an assessment of the limitations and opportunities present in common approaches to multicultural treatment processes (WHO, 2013). It is evident from the results of this research study that Somali refugees and immigrants, apart from being minorities, face special mental health challenges related to their language, culture, religion, income, work and social standing. From what I have found, I recommend that; States and the federal government make provisions to increase spending on mental health programs which will provide access to quality mental health care to minorities in the United States of America. It is also evident that mental health providers need to provide patient centered mental health services which take into consideration patients religion, first language, and cultural background. One way to do this is to make available programs which train immigrants as counsellors for their peers (Park, & Sage & Mahon, 2009). This way, it is easier for an immigrant to express themselves in a language which can be understood. Similarly, it would be appropriate to expand access to culture appropriate community counselling services which provide culture and religious appropriate counselling services to immigrants.

Implications

Problems related to immigrants and refugees' mental health are fundamental to United States' immigration policy development. First and foremost, the mental health of immigrants and refugees is an important determinant of general measures of population health, and therefore is directly related to issues of the cost and adequacy of United States' healthcare system. Second, the mental health of United States' immigrant

population is an important determinant of the costs and benefits of United States' immigration policy and relates to questions such as whether United States is maximizing the return of its large-scale immigration program (Royse, 2009). Differences in the rate of utilization of mental health services are known to exist in different ethnic minority communities, highlighting the need to understand mental health help-seeking in specific cultural groups, rather than lumping visible minority or ethno-cultural communities together. Thus, understanding Somali immigrants and immigrants' mental health services utilization will facilitate the planning and delivery of preventative mental health services to this population, so that Somali immigrants and refugees will be encouraged to enter the mental healthcare system before psychological distress becomes unmanageable (Ponterotto, el at, 2011). Furthermore, an understanding of help-seeking attitudes of this immigrant group can help to identify mental health needs, provide practitioners and policy makers with information regarding interventions and alternative resources which can add to, or complement, efforts to provide equitable and effective care to this growing community in many United States urban areas Surgeon General, 2009).

The findings of this study have implications for mental health providers and other mental healthcare professionals as they provide a framework for working with Somali immigrants and refugee immigrant populations. Mental health professionals serve an important role in increasing Somali immigrants and refugees' utilization of mental health services (Van, & Bartels, 2014). However, barriers related to poor access to information and treatment need to be addressed. Mental health professionals working in community and primary care facilities, when performing evaluations of Somali immigrant and

refugee population at risk for mental health issues, can educate and treat this population on symptoms of emerging mental health problems and help decrease the stigma attached to such issues. Mental health professions, in their role as educators, can address the stigma of seeking help by providing information about mental health problems and mental health services options (Krippendorff, 2013). Most discussions of immigration focus on human capital, usually translated as education and job skills. Health, like education, is an important component of human capital. Policy decisions have important and potentially far-reaching repercussions for new settlers. For example, most provinces impose a mandatory waiting period of three months for a person to qualify for health care. When the waiting period is over there is a surge in immigrant health visits. The consequences of mandatory waiting periods, and their effect on decisions regarding preventive health care, require careful study (Matthews, & Hughes, 2001).

Religious communities and cultural groups also might take the lead in establishing primary care programs and services that serve their respective populations. This can be achieved through collaboration between health authorities, service providers, and immigrants and refugees (Reay, Stuart, & Owen, 2013). Health, social and community agencies need to enhance their websites with comprehensive information describing if and how they accommodate the mental health needs of immigrants and refugees. Somali immigrants and refugees may be uneducated on matters pertaining to mental health concerns (Adewuya & Makanjuola, 2008). They may be unaware of the existence of mental health services that may be available within their community. One way to increase awareness about the availability of mental health services would be to

encourage education about the detection of mental health problems and the availability of mental health services among Somali immigrants and refugees. It is, however, important to note that mere awareness of the availability of mental health services may not be enough to increase their utilization (WHO, 2014). (WHO

Social Change

This study may contribute to social change by documenting the many mental health challenges faced by Somali refugees and immigrants and refugees. Respondents demonstrated a limited understanding of mental health challenges, and where to find help if faced with mental health disease. This study further documented coping strategies used by Somali refugees, and the role of community in offering alternative mental health services. The roadblocks to accessing care have also been dealt with extensively, together with some recommendations to making care accessible. In addition, this study contributed to social change because it to determined how Somali immigrant and refugee perceived effectiveness of mental health treatment, which is being impacted by cultural and language differences between patients and mental health professionals.

A qualitative study is the ideal method of choice which has been chosen because is the most preferred model which allows the first-hand exploration of the experiences of Somali immigrants and refugees adapting to life in the United States, and provide essential information that is currently not available through other research methods (Martin, 1994. Furthermore, the recommendations of this study have wider implications to offering affordable and accessible care to a wider group of minorities in this country. Regarding positive social change programs, the researcher advocates for a comprehensive

healthcare reform program which integrates mental health programs for Somali immigrants and refugees with a main objective to provide bilingual mental health services to Somali immigrants and refugees. Such a program would utilize trained Somali refugees and immigrants to reach out to other Somali immigrants and refugees who need of mental health services, and would go a long way to provide health education to Somali immigrants and refugees on their rights as patients, and to promote state provided professional mental health services, and where to find them. This also would bridge the gaps between mental health professionals and Somali immigrants and refugees needing professional mental health services, in Minneapolis Minnesota and positive social change for other immigrant minority groups in United States.

Conclusion

The purpose of this study was to explore the help-seeking mental health problems of Somali immigrants and refugees living in a midwestern state. The results of this study underscore the need for increased understanding of this group of the population as they navigate through the healthcare system. Somali immigrants and refugees who participated in this study experienced many immigration-related stressors. It is researcher's hope that the findings of the present study will lead to implementation of culturally sensitive and competent programs for Somali immigrants and refugees that consider their values, norms, beliefs, and perceptions of mental health and mental health problems. In addition, it is the researcher's contention that more research studies need to be conducted to examine further the qualitative domains identified in this study,

especially cultural adjustment issues, knowledge of availability of services, and stigma as far as mental health treatment is concerned.

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Appendix A: In-Depth Interview Guide

Part A: Perceptions about Mental Health Problems

1. Can you please explain to me in your own words what does the term "mental health problem" mean to you?
2. Please describe to me some of the mental health challenges you are facing as a Somali refugee living in United States?
3. Please can you tell me what you think cause mental health problems? (prompts), have there been changes in the way you perceive mental health problem since you came in United States over the years?
4. Please can you tell me how the people you live with reacted to your mental health problem?

Part B: Perceptions Regarding Mental Health Treatment

5. Can you tell me about where you go to seek help for mental health care? Why did you prefer to seek mental health treatment from this source?
6. Please from your experience of seeking mental health treatment what worked well for you and why? What did you not like and why?

Part B: Factors Affecting Mental Health Treatment

7. Please tell me about what challenges do you face that made you to drop out of mental health treatment?
8. Tell me about mental health resources you were able to access during your stay in United States?
9. When was the need to seek help identified and what kind of help was sought (prompts) were any rituals, prayers or ceremonies part of the help-seeking in dealing with crises?
10. Please tell me what happened in your interaction with your mental health provider? Is there anything you would like to have done differently, and if so, how?

11. What other types of mental health services are available in your community that you aware about? Why did you not prefer these services?

12. Please tell me what you wish the service providers can be done to improve the services you received?

Appendix B : Demographic Survey Questionniare

1. What is your sex?
    - Male
    - Female

2. How old are you?
    - 15-18
    - 19 -21
    - 21-25
    - 25=30
    - 30-35

3. What is your marital status
    - Single
    - Married
    - Never been married
    - Remarried
    - Divorced

4. What is the highest education level of education you have attained
    - Elementary school
    - Middle school
    - High school
    - College/ University

- None

5. Which language(s) do you speak
   - English
   - Somali
   - Spanish
   - Other (specify) ----------

6 How old were you when you came in this country?
   - Less than 10
   - 10-20
   - 20-30
   - 30-40
   - 40 and above
   - Born in United States

7. Is any of your parents still alive? If none, at age did you become a complete orphan?
   - Parent (s) still alive
   - Less than 10
   - 10 20
   - 20-30
   - 30-40
   - 40 and above

8. What is your current annual Income?
    - $12,000
    - $16,000
    - $10,000
    - $20,000
    - $12,000
    - $15,000
    - $19,000
    - $14,000

Appendix C: Transcription

ID Number	Question 1: Age
1	20
2	20
3	21
4	32
5	35
6	36
7	23
8	33

ID Number	Question 2:Sex
1	Female
2	Male
3	Female
4	Female
5	Male
6	Female
7	Female
8	Male

ID Number	Question 3: Married Status
1	Married
2	Married
3	Married
4	Married
5	Married
6	Married
7	Married
8	Married

ID Number	Question 4: Number of Children
1	8
2	5
3	3
4	1
5	8
6	3
7	5
8	5

ID Number	Question 5: Years in United States
1	5
2	13
3	11
4	8
5	5
6	5
7	6
8	12

ID Number	Question 6: Education
1	High School
2	High Scholl
3	College Degree
4	College Diploma
5	College Degree
6	College Diploma
7	High School
8	College Diploma

ID Number	Question 7: Annual Income
1	$ 12,000
2	$ 16,000
3	$10,000
4	$ 20,000
5	$ 12,000
6	$ 15,000
7	$ 19,000
8	$ 14,000

Table 1

Participant Demographics

ID	Age	Sex	Marital status	Children	Years in United States	Education	Annual income
1	20	female	Married	8	5	high school	$12,000
2	20	male	Married	5	13	high school	$16,000
3	21	female	Married	3	11	degree	$10,000
4	32	female	Married	1	8	diploma	$20,000
5	35	male	Married	8	5	degree	$12,000
6	36	female	Married	3	5	diploma	$15,000
7	23	female	Married	5	6	high school	$19,000
8	33	male	Married	5	32	diploma	$14,000

Table 2

Perception About Mental Health Challenges

Gender	Respondent #	Theme
Female	1	"For me when I think or hear about mental health challenges, I often draw a conclusion those individuals have madness including being crazy, somebody may be afraid of challenges it may also be somebody the families or friends could be afraid of challenges because in my culture, such individuals you may definitely cannot go around gossiping or talking about this individual openly and freely."
Male	2	'"I often feel uncomfortable and kind of weird when I hear the word mental health challenges because in my culture, it is very rare. In my whole entire life, I have never thought of discussing mental health challenges with strangers. According to my culture, it is something which you cannot share with any stranger and you cannot think of mentioning to anybody because it is a very scary stuff."

Female	3	"I think the mental health problems means to me like somebody who is mad or crazy or somebody whose brain is frozen. Because of serious stigma on mantel illness, I often get afraid when I hear about any topic being discussed openly during serious conversation. In our culture, we don't talk about it because it is considered one of the taboos in Somalia."
Female	4	"I think mental health challenges means fear including being crazy, madness, weird issues not to be discussed in public, and being overload with a lot of negativities including psychiatric disorders, depression disorders and schizophrenia disorders."
Male	5	"I think that mental health problems for me it means the state of being in right mind and consciousness without any internal and external disturbance temporally or permanently."
Female	6	Mental health illness is I mean psychological mental health which, damage to the brain or related to psychology of individual due to over thinking. Personally, I really think of psychiatric, depression, and schi-zo-phre-nia. (stammering on the word) those diagnosis that you hear about every now and then on television shows, in commercials and magazines."
Female	7	"I think mental health problem means to me as state of being mad and losing touch with realities and having a frozen brain."
Male	8	"To me mental health problems are losing wires in your brain, being possessed by demons or possessed by the ancestors from Africa."

Table 3

Gender	Respondent #	Theme
Female	1	"Some of the mental health I have been facing is that when mental health stressor including PTSD whereby my heart sometimes will feel like jumping out of my chest. Sometimes I feel like my heat is pumping to much or working too much which makes me react like a crazy person and it is like saying that everything is going to be all right, or my brain or mind will be able to snap so that I could calm down or be able to slow down. Sometimes I feel like my body becomes very tense."
Male	2	"I have been facing the impact of civil war trauma including cultural challenges and language differences. Since I came in United States, I have been having problems of adjustment with racism including limited skills and holding jobs."
Female	3	"My mental health problem is that I have adjusting challenges which increase the risk of developing my behavioral and mental health problems. For example, missing my siblings and other relatives in Africa. I sometimes find it very difficult to work because of intense symptoms and signs of depressions stems from my family demands and obligations."
Female	4	"I have language barriers which is making me not to access mental health services with mental health providers. I also have pain in my brain because the devil is very busy hunting for my life. I also feel very weak and do not have any strength at all. I normally get very frustrated with mental health providers because when I am seeking for mental health treatment I hope to get better right away and if I do not get it, I feel very frustrated and disappointed. I normally seek for treatment with the hope that all my mental health challenges I have will go away."
Male	5	"Because of the trauma that happened to us during the war, and language barrier, I am not able to receive the treatment for mental health condition. There was a day when I was overwhelmed up to the extent of hitting my head on the walls in order to releases my pain, but instead I started to crying like a two-year baby girl. I started asking myself the reason why I

		came to this country because of being frustrated with the way how mental health service systems works. I have been very frustrated because of my cultural beliefs and background and facing a lot of challenges with cultural beliefs whereby I get frustrated with how the system works."
Female	6	"Language issues is one of my biggest barriers to utilize for my mental healthcare services. For example, mental health providers often misunderstand me whenever I visit health care service, I think either because I am lacking all the abilities to express myself in English language or speak fluent English language because of my I never went to school here in America. Lack of communication accessing mental health services, including desires dealing with challenges is also one of my concerns which is the main problem. I would also say that understanding is practitioners is also my biggest challenges because of cultural differences and linguistic differences including living with the fear being stigmatized which has been my hindrances that I often hold me back from seeking mental health help."
Female	7	"Yes, when I came to United States, I had a dream and goals, but my dreams and goals changed because of my son's mental illness. However, back home in my country for example, if somebody is mentally challenged or have issues with mental disability you are not treated well because of communication barriers part which is the biggest challenges. I can say so because many of these challenges stem from discrimination and racism which often create tension, misunderstandings and confusion. I have also a problem struggling with socioeconomically specifically because I do not know English language including financial hardship and obligations."
Male	8	"It was hard for me to deal with my challenges communication barriers and maintain my normal life in this country and everything as far as my goals are concern. Lack of communication support from mental health provider including misunderstanding which often makes me cry and lack of sleep."

Table 4

Table showing relatives' response to mental health problems in the respondents

Gender	Respondent #	Theme
Female	1	"People from my community did not care about my mental health status."
Male	2	"In my culture, men are not supposed to cry so my relatives told me to act like a man and suck it up."
Female	3	"People from my family think that I have been be witched or demon possessed."
Female	4	"My family isolates themselves from me and they think that I am also a human being."
Male	5	"My family thinks I am worthless."
Female	6	"My family thinks that I have been cursed by some family members."
Female	7	"My family thinks I demon possessed."
Male	8	"My family thinks negatively about my fate."

Table 5

Table showing where respondents seek mental health treatment

Gender	Respondent #	Theme
Female	1	"From families, religious leaders and my cultural leaders often get encourage which help me to progress in my goals and dreams as time goes by"
Male	2	"To the mosque because of lack health insurance"
Female	3	"To community leaders because of my cultural beliefs"

Female	6	"To family members because of my cultural back ground and beliefs"
Male	5	"To community center to get encouragement that helped me to progress well as time goes"
Female	6	"To hospital because I have the insurance"
Female	7	"To the hospital because I trust the mental health providers"
Male	8	"To cultural leaders because I trust in them"

Table 7

Table highlighting what worked for respondents when they sought mental health treatment.

Gender	Respondent #	Theme
Female	1	My belief. I am a religious person. I did not like their routine, and their lack of social interaction
Male	2	My prayers because Allah answers my prayers. I did not like the way they present themselves when praying
Female	3	My strong family values because my family care about each other
Female	4	My family beliefs because my family believes in God
Male	5	My prayers because I have faith in my God.
Female	6	My religious belief strengthened my faith
Female	7	My religious background helped me to have confidence
Male	8	My cultural values helped me to think about the future not the past

Table 8

Table showing challenges which led to respondents falling out of treatment

Gender	Respondent #	Theme
Female	1	Because it is a long process
Male	2	In my culture, people do not discuss their mental health issues, and people with health mental problems are often kept within community or at home
Female	3	It is not uncommon for racial and ethnic minorities to express psychological problems as physiological symptoms.
Female	4	In my culture, people use herbal medicine and traditional medical health practices for mental health and overall health treatment
Male	5	Because my beliefs and faith are part of the healing process and reading the Qur'an prior to treatment as a way to improve the outcomes.
Female	6	Discouragement from family members
Female	7	Because of language barriers
Male	8	Because of believing in my faith as a healing process

Table 9

Table showing mental health resources accessible by respondents here in the USA

Gender	Respondent #	Theme
Female	1	I have seen a counsellor at the mosque
Male	2	I have seen a psychologist in a mental health facility

Female	3	I have seen a marriage counsellor
Female	4	I have seen a religious counsellor
Male	5	I have seen a family counsellor
Female	6	I have seen a psychiatrist
Female	7	I have seen a case worker
Male	8	I have seen a social worker

Table 10

Table showing when respondents saw the need to seek help and what kind of help?

Gender	Respondent #	Theme
Female	1	When I was depressed, I saw the Imam and talked to him about my issue.
Male	2	When I was homeless and our family had nowhere to live and nothing to eat, I went to the mosque to ask for help
Female	3	When I arrived as a refugee they directed me to the catholic shelter where I could find food, clothes and other basic needs
Female	4	When I had problems with my husband because he was cheating on me, I became stressed and my friends counselled me and directed me to seek professional help from the cultural leaders who would talk to my husband
Male	5	When my children became uncontrollable, I became stressed, and it got worse when the oldest run away from home. I had to report this to the community leader who intervened.
Female	6	When my child started using drugs, I went to the community counselor and he talked to my children about their unacceptable behavior and helped him join a rehabilitation program.

Female	7	When my mental health provider had a misunderstanding with me, because of my cultural background I went to the mosque
Male	8	I started gaining weight and became really sick with pressure.

Table 11

Table showing what respondents think can be done differently by their mental health provider.

Gender	Respondent #	Theme
Female	1	They should be knowledgeable, about our cultural beliefs and should have skills to handle mental health issues for immigrants.
Male	2	They should be compassionate and respectful
Female	3	They should be patient and kind
Female	4	They should kind to us and visit us at home
Male	5	They should be respectful of our culture
Female	6	They should have a good interpreter and should be more accepting of immigrants
Female	7	They should have empathy and they should give us free services.
Male	8	They should understand the culture and the beliefs of immigrants.

Table 12

Table showing what kind of mental health services are available to respondents in their communities

Gender	Respondent #	Theme
Female	1	I do not know
Male	2	Community Christian counselling
Female	3	State hospital services
Female	4	Hope After Rape, and Catholic Relief Services
Male	5	Christian church counsellors
Female	6	Private counsellors who advertise in the newspaper
Female	7	Case workers for the state
Male	8	Hospital counselors

Table 13

Table showing recommendations for mental health services.

Gender	Respondent #	Theme
Female	1	They should be knowledgeable, about our cultural beliefs and should have skills to handle mental health issues for immigrants
Male	2	They should be compassionate and respectful
Female	3	They should be patient and kind
Female	4	They should kind to us and visit us at home
Male	5	They should be respectful of our culture
Female	6	They should have a good interpreter and should be more accepting of immigrants

Female	7	They should have empathy and they should give us free services
Male	8	They should understand the culture and the beliefs of immigrants.