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Exploring Factors Influencing Refugees' Mental Health Help-Seeking

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ABSTRACT

Newly resettled refugees are at a higher risk of mental health disorders, but few seek formal psychological help. The purpose of this study is to explore the factors influencing refugees' formal mental health help-seeking. Data were collected by surveying a sample of 45 refugees from three countries of the Great Lacs Regions of Africa: Burundi, Congo, and Rwanda. Multiple linear regression was conducted to examine the association between formal mental health help-seeking and factors of mental health knowledge, stigma beliefs, and socioeconomic factors.

Results show that mental health knowledge factors and the stigma belief factors measured as stigma towards socializing with people with mental health issues, and stigma towards treatment-seeking individuals was associated with formal psychological help-seeking. The effect of social support on formal mental health help-seeking was not statistically significant. The results were supported by the literature reviewed, which indicates that the lack of knowledge and stigma are the leading causes of the refugees' underutilization of mental health services.

The presents study has several implications for practice, policy, resettlement process and research. This study intends to inform mental health practitioners, as well as resettlement agencies about the factors that may get in the way of formal help-seeking after refugees have been assessed as requiring mental health services. Besides, the results of the present study would guide the routine screening and referral to be accompanied by an individualized intervention targeting identified factors hampering the intentions for

formal mental health help-seeking. These results could be used to facilitate action plans

for mental health service delivery for refugees in the process of resettlement.

Exploring Factors Influencing Refugees' Mental Health Help-Seeking

A Thesis

Presented to

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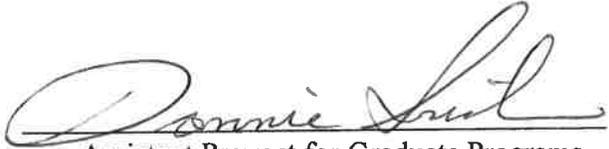
Master of Social Work

By

Frediane Ndikumana

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This thesis, directed and approved by the committee for the thesis candidate Frediane Ndikumana, has been accepted by the Office of Graduate Programs of Abilene Christian University in partial fulfillment of the requirements for the degree

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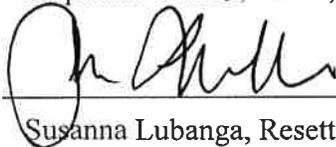
Susanna Lubanga, Resettlement Director, International Rescue Committee

To my husband and my precious children, Dannie, Acsa, and Diora, who supported me throughout this academic journey, I dedicate this thesis. Your encouragement, patience, love, care, and unceasing prayers took me this far. You mean the whole world to me.

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INTRODUCTION

Problem Statement

The post-migration period may be as challenging as the period spent in refugee

camps during the after-war period. A handful of studies exist which indicate that refugees

do not seek mental health help when needed (de Anstiss et al., 2009; Fung & Wong,

2007; Na, Ryder, & Kirmayer, 2016). Moreover, numerous studies were conducted,

highlighting barriers that hamper refugees' mental health help-seeking (Reynders,

Kerkhof, Molenberghs, & Van Audenhove, 2014; Schomerus & Angermeyer, 2008).

However, there is limited knowledge about specific factors influencing refugees' mental

health help-seeking, mainly refugees from the Great Lacs Region of Africa.

Immediately after their arrival, refugees receive different orientations about

navigating different US systems, such as the physical health system, the welfare system,

the education system, and the transportation system on their own. Additionally, refugees

must start working towards their self-sufficiency goals within a minimal amount of time

While refugees from countries torn by conflicts appear to be resilient, the daily life

stressors may disrupt their normal functioning, causing the development of mental

disorders or worsening a preexisting condition.

Despite the alarming fact that refugees are at a higher risk for mental disorders,

very few seek help for mental health issues (Rickwood & Thomas, 2012). Unlike other

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physical or material needs, mental health may not be apparent to the refugees themselves or to the resettlement agency that serves them. On the one hand, due to linguistic and cultural obstacles, refugees find it difficult and sometimes impossible to explain mental health-related problems. Consequently, refugees do not get adequate and meaningful assistance with their mental health needs. Similarly, due to a lack of understanding of mental health symptoms, refugees seek help from their primary care providers or other community health centers. On the other hand, mental health providers' lack of understanding of the refugees' cultural background is another contributing factor to the inadequacy of services provided to refugees, which may prevent them from seeking help, or pursuing treatment.

Recognizing, preventing, and appropriately treating common mental health problems among refugees should be a combined effort of all agencies, organizations, and individuals working on different capacities with refugees. Resettlement agencies and refugee communities need to increase their involvement in addressing this social and global issue. Existing research indicate that there growing initiatives towards increasing the utilization of formal mental health services by refugees (Colucci, Szwarc, Minas, Paxton, & Guerra, 2014; Colucci, Valibhoy, Szwarc, Kaplan, & Minas, 2017; Polcher & Calloway, 2016; Salami, Salma, & Hegadoren, 2018).

Newly resettled refugees are among the most vulnerable populations for physical and mental health disorders (Colucci, Valibhoy, Szwarc, Kaplan, & Minas, 2017; Nazzal, Forghany, Geevarughese, Mahmoodi, & Wong, 2014; Salami, Salma, & Hegadoren, 2018). Those from the African Great Lacs Region, i.e., Burundi, Democratic Republic of Congo and Rwanda, are not an exception. Although the U.S. is considered a safe place

for refugees, many come with their past traumatic and painful experiences from their home countries, which impacts their emotional and mental well-being. Due to life-threatening experiences during the war, in exile, and during the resettlement process, refugees may be an unusually high risk for mental disorder symptoms ("Guidelines," 2017). Refugees who have been exposed to severe violence in their countries of origin are at risk for trauma-related disorders such as PTSD and major depression. According to Nazzal and colleagues (2014), many refugees suffer from mental health issues as they go through the resettlement process in their new host country. Likewise, studies have shown that the prevalence rates of mental disorders increase with time as refugees face their daily life stressors (Lindert, von Ehrenstein, Wehrwein, Brähler, & Schäfer, 2018; Racine & Lu, 2015; Turrini et al., 2017). Due to the numerous barriers to accessing mental health services, refugees do not always seek mental health services when needed.

Thus, in its effort to respond to the growing concern about refugees' mental health, the Center for Disease Control and Prevention (CDC) has developed a guideline for incorporating mental health screenings for newly arrived refugees into the domestic medical examination process ("Guidelines," 2017). During the fiscal year 2016, the Office of Refugee Resettlement (ORR) funded a refugee mental health technical assistance project. This project aimed to offer refugee resettlement providers the opportunity to provide consultations on mental health screening and referrals, to train and build the capacity of resettlement organizations, to provide culturally appropriate mental health services and to facilitate research and usage of evidence-based mental health interventions (ORR, 2016).

As initiatives on refugee mental health immerge at local, state and federal levels, the question remains to know as to whether refugees are empowered to seek help and to access mental health services. Studies have been conducted around mental health and refugees on varied aspects and concepts. Some researchers have explored mental health screening and capacity building through training for those working with refugees (Goodkind et al., 2014; Hocking, Mancuso, & Sundram, 2018; Shannon et al., 2012). Refugee mental health screening is seen as an essential step but would require scrutiny to know the right time to do it (Polcher & Calloway, 2016). Other researchers have focused attention on the need for mental health interventions suitable to the different resettlement stages, i.e., the pre-flight, flight, and the post-migration (Murray, Davidson, & Schweitzer, 2010; Silove, Ventevogel, & Rees, 2017). Thus, it is well-known that the past traumatic events experienced by refugees coupled with the post-migration risk factors may negatively affect refugees' psychological well-being to the extent that they may need to seek help.

During the resettlement process, refugees receive a medical orientation and a physical health check at the health department clinic. Based on the CDC report this first encounter between newly arrived refugees and caseworkers may be an excellent opportunity to educate refugees about mental health issues, discuss expected stress response, and provide them with information about mental health resources available in the community (Guidelines, 2017). Due to factors such as communication barriers, the intensity of the orientations, and the limited time allocated for those checkups, the needs for trauma-related mental health care for the newly resettled communities have been identified as a challenge to the public health system (McDonald & Sand, 2010).

Some researchers such as Hollifield et al. (2013) emphasize the need for health care providers to assess mental health symptoms and trauma-related behaviors within refugees during the first physical health check. Nevertheless, Polcher & Calloway (2016) postulate that the first days of arrival may not be a good time to assess mental health symptoms in refugees since they are still in the honeymoon stage, and therefore, the scores may be skewed.

Background Information

To address refugee mental health issues holistically and to be able to improve help-seeking, it is essential for those who serve refugees, especially resettlement agencies, to have accurate information to answer the following questions: Are refugees educated about mental health? Do refugees know about mental health services available in their community? What factors prevent refugees from seeking help for mental health issues?

The literature has been reviewed to answer these questions while providing definitions for key terms. The literature review illustrates available research about the factors that may hamper refugees from seeking help for mental health. It also suggests that emerging research on refugees' mental health help-seeking have focused on the barriers to accessing services, the importance of early screening, and a community-based approach coupled with psychoeducation as an evidence-based intervention (de Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009; Golberstein, Eisenberg, & Gollust, 2009).

Research (Bogic et al., 2012; Silove, Ventevogel, & Rees, 2017) has shown that there is a gap between perceived needs for mental health services and the refugees' intention to seek help. Hollifield et al. (2013) wrote that although these perceived needs

may be uncovered using various screening tools and through referrals, it is well

documented that these best practices do not guarantee that refugees will seek help after a

positive screening (Shawyer et al., 2014; Sen, 2016; Polcher & Calloway, 2016).

CHAPTER II

LITERATURE REVIEW

Introduction

This chapter explores and critically analyzes studies that have been conducted

within the same scope of the present study: exploring factors that influence refugees'

mental health help-seeking. This comprehensive literature review aims to guide the

researcher in identifying different factors associated with mental health help-seeking.

Additionally, this chapter seeks to answer the following overarching research questions:

Are refugees educated about mental health? Do refugees know about mental health

services available in their community? What factors prevent refugees from seeking help

for mental health issues? At the end of this chapter, specific hypotheses are listed so that

each hypothesis can be tested with empirical data.

 In order to identify information to answer these questions, a systematic search

strategy was used. The literature search was conducted using OneSearch with emphasis

on ACU EBSCO, SocIndex, Psychinfo, and Medline. Criteria included sources from

scholarly, peer-reviewed articles. Google Scholar was also used to find relevant articles.

Selection of articles was limited to those published between 1997 and 2018. The

following key search terms were used in the primary search, to find appropriate

references: ([mental health* or PTSD* or trauma or anxiety* or depression*) and

(refugee* or imigrant*]), help-seeking*, resettlement, needs assessment, mental health

awareness, education of refugees, mental health screening, intervention, referral for treatment.

Refugee Resettlement Process

The United States, as one of 28 countries in which refugees are resettled, committed to resettling 110,000 refugees in 2017. However, the current administration has revised that number and set the refugee admission cap to 45,000 for 2018 (Thorpe, 2016). The implication of this decision on refugee mental health is undoubtedly enormous. Its immediate effect may be observed on the refugee family reunification process, which has been identified as harming the refugee mental health outcome (Choummanivong, Poole, & Cooper, 2014; Miller, Hess, Bybee, & Goodkind, 2018).

While all refugees settled in countries where they have received a temporary refuge may seem to live under the same social and economic conditions, the resettlement process gives priority to those refugees identified by the United Nation Human Commission for Refugees (UNHCR) to be more vulnerable. Thus, the term refugee is defined in the Refugee Act of 1980 as:

> Any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.
> (Kennedy, 1980)

This general definition seems to align with the definition provided by the International Rescue Committee. This U.S. resettlement agency defines a refugee as: "a person forced to flee their home country to escape persecution, war or violence" (International Rescue Committee, 2017).

Challenges in Resettlement

According to existing literature on refugee mental health, it has been noticed that posttraumatic stress disorders are the most researched mental health conditions for refugees (Lindert et al., 2018; Stenmark, Catani, Neuner, Elbert, & Holen, 2013; Thompson, Vidgen, & Roberts, 2018). This may be explained by the fact that nearly all refugees who are resettled in the United States might have experienced a traumatic event, commonly due to war or persecutions.

Studies have found that refugees resettled in western countries could be ten times more likely to have posttraumatic stress disorders than in the general population (Fazel, Wheeler, & Danesh, 2005; Turrini et al., 2017). Nevertheless, evidence shows that most of the countries receiving refugees are not well prepared for the magnitude of mental problems that these refugees bring with them (McDonald & Sand, 2010). In addition, a pilot study conducted emphasized the need for mental health screening especially for PTSD, stress and anxiety among the refugee population (Polcher & Calloway, 2016). The findings of this pilot study confirmed that PTSD symptoms in refugees may not be easily interpreted by those refugees with mental health issues. As a matter of fact, this lack of an appropriate interpretation of PTSD symptoms may hinder the refugees' initiative to seek help.

PTSD in refugees not only has a direct impact on individuals who have experienced traumatic events in their lives, but also on their children. It was found that refugee parents with PTSD have a harsh parenting style, which can lead to adverse effects on their children's mental health (Bryant et al., 2018). While posttraumatic stress disorder in refugees is a reality, Da et al. (2018) considers that mental health service providers are challenged in many ways, including but not limited to effective trauma-focused interventions suitable to the refugee population. Nevertheless, Tribe et al. (2017) conducted a systematic review, aiming at providing a summary of current literature on psychosocial interventions for refugees who had experienced PTSD, stress and depression. The findings have shown that few interventions/therapies were supported by evidence, such as the Narrative Exposure Therapy (NET), the standard Cognitive Behavioral Therapy (CBT), and Eye Movement Desensitization and Reprocessing (EMDR). Regardless of which intervention works with this group of individuals, it is important to know when it is a good time to assess for PTSD in refugees in order to provide a better outcome.

Thus, according to Dinesh (2004) the preflight, flight and post-migration phases have different causes associated with mental health conditions. The pre-flight phase is associated with the period during which refugees experience traumatic events related to war, persecutions, torture and other adverse situations which may affect the whole or part of the social, emotional and psychological functioning. The flight phase, which is the period marked by the journey taken by refugees toward countries of resettlement, may be a leading cause of trauma. For most refugees, this may be their first long trip taken, which may be fearful and tiring. Moreover, starting a new life and coming across

different challenges, such as language barriers, social isolation, unemployment, or acculturation difficulties, can lead to the development of PTSD among refugees.

This period is followed by the honeymoon phase wherein refugees are under the care of the US government through various services administered and facilitated by resettlement agencies. During this phase, any behavior that refugees manifest may have an interpretation, which may not be directly tied to posttraumatic stress disorders, but rather to an excitement caused by change. This idea supports what researchers have found regarding the right time for screening for mental health disorders in newly resettled refugees. ("Guidelines," 2017; Polcher & Calloway, 2016) stipulated that assessing for PTSD may not yield better outcomes when done during the honeymoon phase.

Screening for Resettlement Eligibility

The resettlement process starts with countries where individuals are recognized as refugees by the United Nations. This 36-month long process is conducted through the US Refugee Admission Program (RAP). Most of the refugees who are resettled in the US are referred to the RAP by the United Nations High Commission for Refugees (UNHCR), or any other US-approved humanitarian aid organization. (International Rescue Committee, 2017). Once this thorough and intense screening is done and refugees are cleared for resettlement, the US government works with the resettlement agencies to help those individuals restart their lives in the US (International Rescue Committee, 2017).

Upon arrival in the US, refugees are greeted and welcomed by caseworkers from the national resettlement agencies, such as the International Rescue Committee. This may be the crucial moment during which refugees and case workers representing the resettlement agency build a rapport and establish the relationship. The Cultural

Orientation Resource Center (2012) has noted that the resettlement agency is the most important source of information and assistance during the refugee's first months in the United States. This implies that the first encounter with the refugees allows the resettlement agency to gather useful information from observation or through the interactions with the new arrivals. A refugee typically resettles in the same area as relatives or close friends who are already established in the US. Otherwise, the resettlement agency decides the best placement site based on factors like the availability of jobs, housing and social services (Cultural Orientation Resource Center, 2012).

Refugee mental health screening. Newly resettled refugees commonly exhibit a combined emotional and psychological distress which may reveal symptoms for existing or developing mental disorders; therefore, there is a need to screen them upon arrival (Hocking et al., 2018; Hollifield et al., 2013; Polcher & Calloway, 2016). To this end, many screening instruments for mental health were developed, targeting different disorders, populations, and users. The usage of some instruments may require a comprehensive training and education about how and what they screen for. As a matter of fact, screening tools were not constructed as one-size-fits-all. While some instruments were designed to be administered exclusively by mental health professionals, there are others which can be used by nonprofessionals. Thus, the Hopkin Symptom Checklist-25 (HSCL-25) has proven valid for the general US population and has been adapted for populations, including Indochinese and Bosnians (Mollica et al., 1987; Ovitt, 2003). The HSCL-25 is not a screening instrument but is used to assess for clinically significant anxiety and depression (Hollifield et al., 2013). The Vietnamese Depression Scale (VDS) was developed to be used in identifying depression in Vietnamese refugees (Kinzie et al.,

2003). The Posttraumatic Symptom Scale-Self Report (PSS-SR) is suitable for diagnosing PTSD in the US population. The Refugee Health Screener-15 (RHS-15) was developed to bridge the gap identified by research, concerning an efficient screening instrument for emotional distress.

Moreover, the RHS-15 was proven efficient across psychiatric diagnoses in a range of ethnic groups of resettled refugees. Therefore, the RHS-15 was not developed from scratch. Hollifield et al. (2013) used other existing instruments such as the New Mexico Refugee Symptoms Checklist-121(NMRSCL-121), the Hopkin Symptom Checklist- 25 (HSCL -25), and the Posttraumatic Symptom Scale-Self Report (PSS-SR) to develop the RHS-15 (Michael et al. 2013; Pathway to Wellness, 2011). In addition, the Harvard Trauma Questionnaire (HTQ) and the Vietnamese Depression Scale (VDS) were referenced in developing the RHS-15. Michael et al. (2013) have conducted an empirical study to test the validity and reliability of the RHS-15 (n=251). Using the RHQ, these researchers found that 77 (30.7%) refugees screened positive, and most of those, n=57 were referred for treatment, n=48 engaged in treatment and n=9 declined treatment. Using a multi-method participatory research, they concluded that the RHS-15 was an empirically developed screening instrument suitable for refugees' common mental disorders (Hollifield et al., 2013)

Based on the above study that has led to the conception of the RHS-15, not all refugees who have been screened positive do seek help. There is still a lack of information from research about the commonalities among refugees who, after screening positive, seek formal help for their mental health problems and factors that influence their

help-seeking behaviors. While screening refugees for specific mental health issues is important, it does not guarantee the utilization of formal mental health services.

Referral for mental health services. The goal of a screening process for mental health is to help refugees access early support/treatment through referrals to alleviate the illness burden. Shannon and colleagues (2016) investigated whether referring refugees for mental health services is successful when referral is considered as a process that involves refugees, communities, different case managers, resettlement agencies and mental health service providers. In their study of a sample of 250 participants, successful referrals were associated with factors such as trust between refugees and service providers, culturally responsive care, and collaboration between referring agencies and the mental health service providers. On the flip side, these researchers found that unsuccessful referrals were characterized mostly by cultural barriers, unwillingness to work with refugees, system and language barriers and lack of collaboration between refugees' service providers (Shannon et al., 2016).

Formal Help-Seeking for Mental Health Issues

Although case managers who identified a potential mental health problem within a client may make a referral for a formal intervention to treat the problem, refugees often do not receive the mental health services as needed (Colucci et al., 2014; Salami et al., 2018). Research that has been conducted about help-seeking discovered that help-seeking is a concept which is hard to define. There is no agreed-upon definition for the concept of help-seeking (Rickwood & Thomas, 2012). However, using the *Oxford English Dictionary*, Simpson & Weiner (1989) define help-seeking as "an attempt to find (seek) assistance to improve a situation or problem." In the medical psychology field, "help-

seeking" can be compared to "illness behavior," which includes factors showing how individuals respond to health symptoms and how they use available care (Lin, Inui, Kleinman, & Womack, 1982). Based on a systematic review of studies which have focused on help-seeking, it was found that different authors have used different definitions for help-seeking. Nevertheless, Rickwood and Thomas (2012) have attempted to provide a definition for mental health help-seeking. Their definition postulates that "in the mental health context, help-seeking is an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern" (Rickwood & Thomas, 2012, p. 177).

Many studies conducted on mental health help-seeking have highlighted different ways and sources from which refugees are likely to seek help (de Anstiss et al., 2009; Lin et al., 1982; Na et al., 2016). Based on existing literature, self-help strategies are developed as a way of dealing with mental illness in discretion. Self-help may be understood as an individual trying to solve a mental health problem on his/her own. Lin and colleagues (2014), in their study conducted on Congolese and Somali refugees with a total sample of 94, have found that once mental health issues were identified, they were first handled within the community with the help of a family member and/or a friend. A review of these studies indicates that help-seeking is a two-fold concept: help-seeking for formal interventions and informal interventions.

The choice of formal intervention was motivated by the need to professional help-seeking for mental health related problems. Although informal intervention is valued in different cultures (Piwowarczyk, Bishop, Yusuf, Mudymba, & Raj, 2014), it may lack the essential elements regarding the assessment, diagnosis and effective treatment. Help-

seeking for formal intervention also may be an avenue for evaluating the progress made towards healing, without which it may be hard or even impossible to reach self-sufficiency.

Maslow's hierarchy of needs (Maslow, 1943) is a suitable theory that can be used to support the argument for the need for improving mental health help-seeking by refugees. Resettled refugees are expected to reach self-sufficiency in certain areas; however, mental health problems can interrupt an individual functioning at all stages of Maslow's hierarchy. Addressing mental health with Maslow's lens entails knowing the stage that may be related the most to mental health issues. As a number of studies have emphasized, stigma is one of the leading causes to the lack of professional help-seeking. The "esteem stage" may be the right area to focus the intervention.

Factors of Formal Mental Health Help-Seeking

There are many barriers to mental health access by people from the refugee population. Various studies have reported factors of formal help-seeking for mental health. The factors are classified by the researcher into three main categories: cultural belief as operationalized into mental health stigma, mental health knowledge, and socioeconomic factors.

Cultural belief factors. Cultural determinants play an important role in mental health help-seeking. According to Saint Arnault and colleagues (2018), a combination of cultural barriers to mental health services with high rate of mental health comorbidity put various groups in a situation of vulnerability. In order to explore how cultural beliefs and values relate to mental health help-seeking by Korean women living in the US, the Cultural Determinant of Help Seeking (CDHS) theory was used. The CDHS theory (Saint

Arnault, Gang, & Woo, 2018) stipulates that cultural determinants of help-seeking are internal social ideas and behaviors that prevent mental health help-seeking. As cultures differ, the CDHS may be considered as an appropriate theoretical framework to explore and analyze how and what cultural factors are more likely to get in the way of professional mental health help-seeking.

Nazzal et al. (2014) articulate that refugees have their own traditional and cultural ways of dealing with mental health issues which may be different from the traditional western model of mental health. It is very well documented that cultural beliefs play an important role in addressing mental health issues within the refugee population (Nazzal et al., 2014; Piwowarczyk et al., 2014). Piwowarczyk and colleagues (2014) have identified that different African groups have different traditional ways of dealing with mental health problems. In a study conducted on Congolese and Somali refugees, these authors found an association between conception of the causes of mental health issues and the type of services and sources of help used by African refugees from the Great Lacs Region of Africa. For some cultures, mental health issues are associated with witch spells, incantations, witchcraft and so forth. Therefore, the help is commonly sought from community members called witches and different religious leaders. Some of these sources of mental health help-seeking may make a diagnosis using divination and prophecies. In most cases, this diagnosis does not consider the problem as a mental health issue. The manifestation of a mental health disorder is associated with as social life issues within African societies (Honwana, 1998).

This way of handling mental health problems by some African refugee groups including those from Burundi, Congo and Rwanda is contextualized as informal, to

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differentiate it from the western model, which is considered as formal. Nevertheless, Honwana (1998) argues that there is common point between the informal or traditional, and the western or modern ways of dealing with mental health issues. This researcher identified culture as the key component in conception, understanding, coping and treating mental health related issues. This is explained by the fact that the ways in which individuals express themselves or give meaning to problems which are often impossible to explain scientifically are strongly tied to social and cultural contexts. Sue & Sue (2008) postulate that the cultures have their different ways of explaining and interpreting abnormal behaviors and their own indigenous healing methods.

Mental health stigma. Stigma is an important component of cultural beliefs related to mental health and the most researched construct (Golberstein et al., 2009; Schomerus & Angermeyer, 2008). Mental health related stigma in the general population at large and in refugee population in particular has been researched. Some researchers postulate that the impact of stigma can be worse than the impact of mental health conditions themselves (Ritsher et al., 2003; Schomerus & Angermeyer, 2008)

Golberstein, Eisenberg, & Gollust (2009) argue that mental health-related stigma may be a determining factor on how and whether refugees seek help for their mental health issues and on the commitment to treatment and the mental health outcome. Other studies have categorized mental health related stigma into three main constructs including: 1) personal or self-stigma, i.e. one's attitude and beliefs towards people suffering from mental illness; 2) perceived stigma as what people believe about others' attitudes towards mental health; and 3) experienced stigma which may entail discrimination on the ground of mental health issues. Stigma impact primarily on

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disclosure (Schomerus & Angermeyer, 2008). As a matter of fact, seeking-help intentions may not be translated into the actual action.

Studies have shown that there are factors that negatively impact mental health help-seeking. Komiya et al. (2000) found that greater stigma is negatively correlated with more favorable attitude towards seeking psychological help. Zartaloudi and Madianos (2010) argued that people are more likely to fear being stigmatized than living with the symptoms and consequences of a mental health disorder.

Mental health knowledge. Refugees' lack of knowledge about mental health and mental health services is associated with the lack of professional help-seeking (Goodkind et al., 2014; Slewa et al., 2014; Wei et al., 2016). Therefore, knowledge of mental health and mental health services implies being able to recognize symptoms of mental illness, the risk factors and the causes of mental illness, he help-seeking patterns and the available treatments and self-help strategies (Na et al., 2016). Nevertheless, the need for understanding and having enough knowledge about mental health is not solely limited to the refugees. Research has proven that those who work with refugees, such as resettlement agencies, physical and mental health providers, schools, and community leaders, need to be educated about mental health disorders common in refugees and how they are perceived by the latter. As Vila-Badia et al. (2016) postulated, a refugee might not know how to interpret their psychological issue and may associate their somatic symptoms with their physical ailments (Martinez et al., 2013; Vila-Badia et al., 2016).

According to Jorm (2012), mental health literacy postulates that individuals can recognize mental illness symptoms and risk factors, know the help-seeking and services options available, and become aware of self-help strategies. Literacy may then be

considered as an intervention that can booster mental health help-seeking in refugees (Jorm, 2000). Across research that has been conducted so far, it has been recognized that increasing knowledge about mental health disorders, services available for refugees, and their perspectives about the effectiveness of treatments are associated with a high level of help-seeking (Jorm, 2000; Jorm, 2012; Jorm et al., 1997). These studies state that mental health literacy could provide a framework which could be used to improve mental health services through education. Therefore, the mental health literacy (MHL) conceptual framework assumes that individuals can learn and acquire basic knowledge about mental health issues and services that can influence and guide their subsequent help-seeking behaviors (Jorm, 2012). As this study is interested in improving mental health help-seeking, it is necessary to understand how the components of the mental health literacy framework could impact the health seeking behavior among the refugee population.

  Socioeconomic factors. Socially disadvantaged individuals, including refugees, are at a higher risk of having their mental health needs unmet (Steele, Dewa, & Lee, 2007). Therefore, the socioeconomic barriers, including limited English proficiency, unemployment, family income, social isolation or lack of social support, to name a few, have been identified as having a negative impact on access to mental health services (Goodkind et al., 2014). While these factors constitute daily stressors for refugees during their post migration phase, research has shown that they impede refugees' financial self-sufficiency and, therefore, hinder intentions for mental health help-seeking for formal intervention (Salami et al., 2018; Silove et al., 2017; Steele et al., 2007).

  Refugees often come to the U.S. with limited or no English skills. This may impact their ability to seek formal help for their mental health issues from different

service providers (Goodkind et al., 2014; Nazzal et al., 2014). In addition, the lack of social support during the post migration period may negatively impact refugees' psychological well and emotional wellbeing, which may result in serious mental health disorders (Miller et al., 2018; Wachter & Gulbas, 2018)

Conclusion

Mental health issues are a reality among refugees resettled in the United States. As demonstrated in the literature, refugees are vulnerable to mental health disorders due to their past traumatic lived experiences. Besides their past, there are other factors which increase the mental health risk for refugees even more. These can include the daily life stressors associated with the struggle which refugees have to go through to reach self-sufficiency. Some of the struggles include challenges to communicate in a new language; integrating into a new culture; navigating a new health care system, a new school system; in brief, starting a whole new life. While refugees are well known to be resilient, mental health may get in the way when refugees strive and reach their goals. Taking care of refugees' basic needs and giving less attention to their mental and psychological wellness may prevent them for reaching their full potential.

Therefore, literature has suggested that dealing with mental health is like fighting the unknown. The combination of a lack of awareness or knowledge about mental health issues and fear of being stigmatized, cultural and religious barriers, and lack of English proficiency, makes it hard for refugees to reach out for formal help. Throughout the literature, it is evident that help-seeking can be done in two ways: formally and informally. Most research conducted on mental health help-seeking was geared toward

the formal model involving a mental health professionals, counselors or psychologists and psychiatrists.

This study explores factors influencing mental health help-seeking, and it focuses on the professional or formal help-seeking. The literature reviewed suggested that factors of formal help-seeking included mental health knowledge, stigma beliefs and social support. This information was combined to develop a research model for this study (Figure 1) and to formulate hypotheses that were tested using the data collected. Demographic factors are included to test the effects of each factor category on the outcome after controlling for these demographic factors.
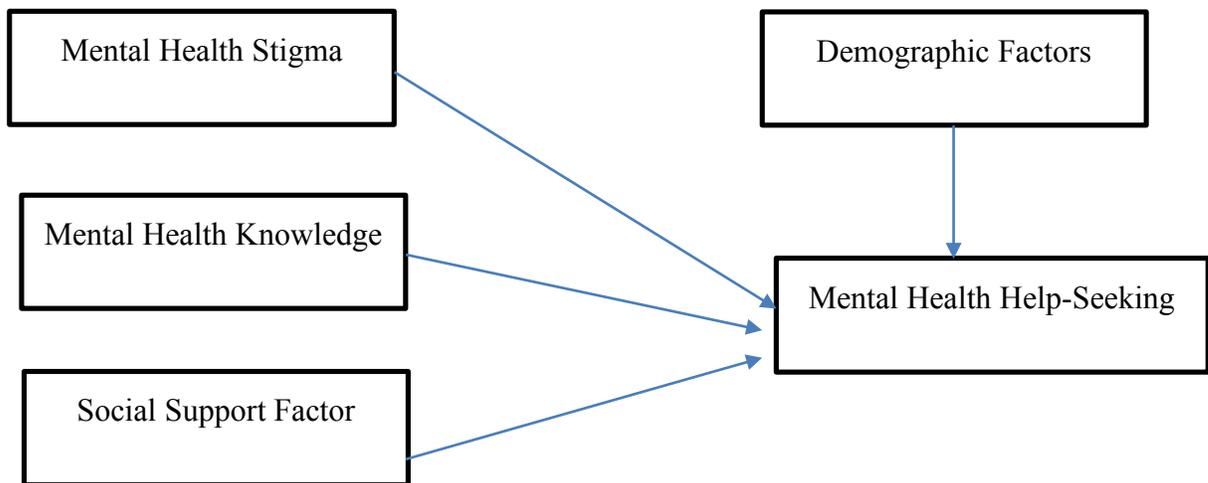
Figure 1: Research Model of Factors Influencing Mental Health Formal Help-Seeking

Each hypothesis may include multiple factors under each area.

Hypothesis 1: Refugees who have a higher level of mental health stigma will seek less formal help for mental health issues.

Hypothesis 2: Refugees who have a higher level of mental health knowledge will seek more formal help for mental health issues.

Hypothesis 3: Refugees who have a higher level of social support will seek more formal help for mental health issues.

CHAPTER III

METHODOLOGY

Introduction

The purpose of this study is to explore the factors contributing to mental health

formal help-seeking among refugees from the Great Lacs Region of Africa, i.e., Burundi,

Democratic Republic of Congo and Rwanda. From the above literature review, factors

that predict formal help-seeking for mental health issues among refugees from the Great

Lacs Region of Africa have been identified: cultural belief factors operationalized into

stigma towards socializing with people with mental health issues and stigma towards

treatment-seeking individuals, mental health knowledge, and socioeconomic factors.

Hence, this chapter describes the methodology that was used to collect and analyze data

and to test the research hypotheses formulated based on the literature review.

Research Design

The present study was conducted using a cross-sectional design with a

quantitative approach. The cross-sectional design was guided by the fact that the study

did not intend to use pre- and post-test. A survey questionnaire was used to collect

information at one point in time, and to determine the relationship between the identified

factors and the outcome variable. The cross-sectional design used presents advantages as

well as limitations. Regarding this study, the advantage is that due to time constraints, the

information needed was gathered at one point in time. In addition to being time-and cost-

effective, the researcher was able to collect data on all variables of interest at once. Unlike longitudinal studies, cross-sectional studies are not prone to threats of internal validity and reliability, such as maturation or some historical events, to name but a few (Zhang & Wildemuth, 2009). The cross-sectional design has several limitations. The major one is that no causal relationship between variables can be proven. The only possible relationship might be attributed to the association or correlation between identified variable and the outcome variable (Yegidis et al., 2012).

Study Population and Sample

The study population was refugees from the Great Lacs Region of Africa (Burundi, Democratic Republic of Congo, and Rwanda). The choice of this population and the setting was driven by studies that were conducted before and the wish to add to this existing body of knowledge for the benefit of refugees struggling with mental health issues. The sampling frame consisted of refugees resettled from Burundi, Democratic Republic of Congo, and Rwanda and who currently live in Abilene, Texas. This study targeted refugees from the above-mentioned countries who were 18 years old and above. The researcher recruited participants by reaching out to IRC caseworkers for names and contact information. Additional participants were recruited by reaching out to the community. Because this sampling frame does not cover most of the study population, it is considered a convenience sampling. The total sample included 45 refugees.

Measurement Instruments

This study explores factors influencing refugees' mental health help-seeking. The outcome variable is formal help-seeking. Independent variables or predictors include the following factors: (1) stigma, (2) mental Health knowledge factors, and (3)

socioeconomic barriers. To measure each of these factors, existing instruments were adapted to fit the refugee population used in this study. Questions irrelevant to this study were left out and replaced by more culturally competent questions. The survey questionnaire was made in close consultation with the management at a local IRC agency.

Formal mental health help-seeking. Formal mental health help-seeking as a dependent variable is measured across literature using varied instruments (Olivari & Guzmán, 2014). This study adapted one of the most frequently used tools, the General Help Seeking Questionnaire (GHSQ). This measurement instrument was developed for personal-emotional and suicidal problems, using a sample of 218 high school students. Reliability and validity of this measurement instrument were confirmed (Wilson, Deane, Ciarrochi, & Rickwood, 2005). The GHSQ was designed in a matrix format which could be modified depending on purpose and needs. Therefore, for the purpose of this study, and after consultation with the professional in the resettlement agency, the items related to the suicidal thoughts were not included in the survey.

Formal help-seeking for mental health issues was measured by listing potential help sources and asking respondents to what extent they were likely to seek help from each source. The instrument specified the nature of the problem (mental health issues) and the possible source of help (doctor and/or mental health professional). The level of help-seeking (Wilson et al., 2005) for formal intervention was measured by averaging the score of the likelihood of seeking help from the "doctor" and the "mental health professional." A higher number (=7) indicates that the respondent is more likely to seek this kind of help than a person who has a lower number (=1).

Mental health stigma. Stigma was identified as the most outstanding factor of cultural determinants for formal help-seeking for mental health issues. The Stigma Scale for Receiving Psychological Help (SSRPH) was used to measure stigma that people associate with receiving formal intervention for mental health problems. Developed by Pinto and colleagues (2015), the SSRPH is a five-item scale, and each of the items is scored on a four-point Likert scale, ranging from 1=strongly disagree and 4=strongly agree, a score of 4 indicating less stigma. Therefore, this scale was adapted to fit the population under this study. After consultation with professionals who work with the population involved in this study, new items (9) were added to the scale. The purpose of including new items was to balance the negative statements in the existing scale as advised by the agency serving this population. Then two subscales evolved: stigma towards socializing with people with mental health issues was measured by items 1-4 and stigma towards normalizing mental health conditions measured by items from 5-10 (Appendix D).

Mental health knowledge. The mental health knowledge factors were measured by the Mental Health Literacy Scale (MHLS) developed by O'Connor &Casey (2015). Mental Health Literacy Scale (MHLS) was a 35-item questionnaire which was developed as a comprehensive tool that could be used to measure the level of mental health knowledge including: ability to recognize disorders, where to seek information, self-treatment, risk factors and causes, professional help available, attitude promoting appropriate help-seeking behavior. The MHLS was a Likert scale ranging from 1=strongly disagree and 4=strongly agree. The scores were averaged, and the highest

mean indicated higher knowledge. Items included in the survey were statements related to the recognition of disorders (Item #1), knowledge of how to seek mental health information (Item #3 & 5), and knowledge of professional help available (Item #2 & 4). A total of 5 items relevant to this study were selected for use.

Barriers to mental health services. A new measurement that included seven items was developed through a discussion among the director and practitioners in a resettlement agency. The discussants reached an agreement on the final measurement that reflected transportation, interpretation, and financial needs. The measurement was constructed based on perceived barriers for refugees to access mental health services. Each barrier was measured using a four-point Likert scale ranging from 1=strongly disagree and 4=strongly agree, 4 indicating that there was no barrier and 1 indicating that there was a barrier.

Social support factor. Social support was an important component of the socioeconomic factors. Social Support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS). A study (Zimet et al., 1990) describing the development of this instrument revealed that it was a psychometrically sound instrument. The internal reliability for this instrument was also reported, ranging from 0.85 to 0.91. The MSPSS is a 12-item scale measuring three factors groups: family, friends and significant other. The scale was adapted to a four-point Likert scale ranging from 1= strongly disagree to 4= strongly agree. Participants are asked to rate the 12 statements by indicating how they feel about each statement, a score of 4 indicating that the respondent had a strong social support.

Economic factor. Since mental health formal help for mental health problems was most of the time associated with a cost, the family income was also measured by the question "What is your monthly income?" Participants were given random amounts as options from which to choose. This information was reported in the demographic information which was used as a control variable.

Data Collection Procedure

Since this research dealt with human subjects, an application for the exempt review was submitted to the Abilene Christian University (ACU) Institutional Review Board (IRB). The approval letter to this request is included in Appendix A. While waiting for the IRB approval, the researcher discussed the research project with three IRC caseworkers who work with the target population on a daily basis. The data collection procedure was explained to those caseworkers, who provided emails for potential respondents. A list of 35 email addresses was compiled. After receiving the IRB approval, the survey questionnaire was translated by the researcher into two different languages to allow participants who were not proficient in English to participate. Individual emails were sent to the email addresses already collected. Paper form questionnaires were distributed to qualified participants during work hours at the IRC office.

Before handing the questionnaire, the informed consent, which is included in Appendix B, was initially explained and signed. The informed consent form was also translated in the two main languages used by the participants. A copy of the signed informed consent form was given to the participants afterwards. Questionnaires were hand delivered to the selected participants by the researcher. Participants who were not

literate were assisted with completing the questionnaire. To ensure confidentiality, no

identifiable information was be collected, such as name and address of the participants.

The survey questions are included in Appendix D.

Data Analysis Plan

Descriptive statistics were conducted to provide the characteristics of the sample

including demographic information such as age, gender, country of origin, marital status,

and level of education. The multiple linear regression analysis was conducted to test the

association(s) between the outcome (mental health formal help-seeking) variable, and the

identified factors such as mental health stigma, mental health knowledge, and social

support.

CHAPTER IV

FINDINGS

Characteristics of the Sample

Table 1 presents the detailed demographic information of the participants. The study participants were refugees from Burundi, Democratic Republic of Congo and Rwanda, who were resettled in the United States through the International Rescue Committee. The descriptive statistics indicated that 57.8% of the participants identified themselves as male and 42.2% as female (n=45). This information shows that both genders were well-represented. The results also show that most of the respondents were refugees from Congo, accounting for 55.6%. Burundian refugees who participated represent 26.6%, whereas respondents from Rwanda account for 17.8%.

Another important fact worth noticing is that more married than unmarried refugees (48.9%) participated to the survey. In terms of the number of years spent in the United States, fifteen respondents (33.3%) have been resettled for one to three years, twelve have been in United States for three to five years, accounting for 26.7%, ten of total respondents have been resettled for five to eight years accounting for 22.2%, and finally seven respondents (15.6%) have been in United States for eight to ten years. A good number of participants, representing 31.1%, reported that they have had no education and therefore could neither read nor write. Participants were also asked if they had any type of medical insurance, and % of the respondents did not select any option.

The results indicate that a small number of all respondents (63.3%) reported that they had no health insurance, and 11% of the participants responded that they had insurance from their employers. Participants who reported having Medicaid accounted for 8.9% and those who were using Medicare were13.3% of the respondents. Such information was crucial to determine if this variable is of any meaningful significance to refugees' mental health help-seeking. None of the respondents answered the question about their monthly income. Therefore, this information is not available in the analysis.

Table 1

Characteristics of the Sample (N=45)

Variable	Category or Range	*N*	*%*
Gender	Male	26	57.8
	Female	19	42.2
Marital Status	Single	15	33.3
	Married	22	48.9
	Widowed	5	11.1
	Divorced	3	6.7
Country of Origin	Burundi	12	26.6
	RDC	25	55.6
	Rwanda	8	17.8
Years in the US	1 to 3 years	15	33.3
	3 to 5 years	12	26.7
	5 to 8 years	10	22.2
	8 to 10 years	7	15.6
Education	No formal education	14	31.1
	Primary school	5	11.1
	Secondary school	13	28.9
	Vocational education	3	6.7
	Baccalaureate degree	1	2.2
	University degree	8	17.8
	Master's degree	1	2.2
Health Insurance	Medicaid	4	8.9
Missing 63.3%	Medicare	6	13.3
	Insurance from the employer	5	11.1
	No insurance at all	2	4.4

Note. The education reflects the standard education systems for the three countries of origin of the survey participants.

Internal Consistency of the Composite Variables

The present study includes some measurement scales. The General Help Seeking Questionnaire (GHSQ) was used to measure mental health formal help-seeking as the outcome variable. The Stigma Scale for Receiving Psychological Help (SSRPH) was used to measure the mental health stigma construct. The Mental Health Literacy Scale

(MHLS) was used to measure the refugees' mental health knowledge, and the Multidimensional Scale of Perceived Social Support (MSPSS) was used to measure the social support variable. Note that the above measurement instruments were adapted to fit the population involved in this study.

Therefore, similar factors were aggregated to calculate a composite variable. According to Song and Colleagues (2013), a composite variable is made up of more than three indicators that are highly related to one another and include scales, single or global ratings, or categorical variables. They claim that using composite variables is a common practice for certain purposes such as "addressing multicollinearity for regression analysis or organizing multiple highly correlated variables into more digestible or meaningful information" (Song and Colleagues, 2013, p.47). The answers to related questionnaires were categorized into a composite variable by taking the mean of their scores.

As preliminary analyses, a series of reliability analyses were performed to check the goodness of the scales by checking the internal consistency of each scale. The internal consistency indicates the extent to which all the items or indicators measure the same construct and the inter-relatedness of the items with each other (Tavakol, & Dennick, 2011).

Cronbach's alpha is a widely-used tool for assessing the internal consistency of a scale. This value refers to "the extent that correlations among items in a domain vary, there is some error connected with the average correlation found in any particular sampling of items" (Nunnally, 1967, p. 206). Nunnally argued the alpha level of equal or higher than .70 is considered to be indicative of minimally adequate internal consistency. Although there are different reports about the acceptable values, this value is widely used

for a cut-off value. The following section provides information including what indicators were included in each scale and its Cronbach's alpha.

Mental Health Knowledge As noted in Table 2, a subscale mental health knowledge exhibited a high internal consistency (Cronbach's α = .920). Therefore, the scores on the five items were averaged to generate a composite value to measure mental health knowledge as O'Connor &Casey (2015) suggested.

Table 2

Internal Consistency of Mental Health Knowledge

Indicator (α=.920)	Mean	SD
I am confident that I know where to seek information about mental illness	2.17	.985
I am confident using the computer or telephone to seek information about mental illness.	2.11	1.023
I am confident I have access to resources (e.g., General Practitioner, internet, friends) that I can use to seek information about mental illness	2.11	1.183
I am confident attending face to face appointments to seek information about mental illness (e.g., seeing the General Practitioner).	2.06	.998

Note. The first item of this scale was excluded from the analysis because most of the respondents did not give an answer.

Barriers to Mental Health Services. As noted in Table 3, a subscale barrier to mental health services access exhibited high internal consistency (Cronbach's α = .756). Therefore, the scores on the 7 items were averaged to generate a composite value to measure barriers to mental health services access.

Table 3

*Internal Consistency of Barriers to Mental Health Services Access (N= 4*5)

Indicator (α=.756)	Mean	SD
I know how to ask for an interpreter at appointments.	2.41	.996
I have access to transportation to health/mental health appointments.	2.86	.930
When someone talks about mental health, I understand what they mean.	2.73	1.128
I have sufficient income to pay for mental health services.	2.39	.945
My insurance would cover mental health services.	1.84	.914
I feel comfortable sharing emotional struggles in my community.	2.07	.950
I have the time I need to see a medical professional (I can take time off work; I have someone to watch my children, etc.)	2.32	.857

Mental Health Stigma

The original plan to measure the construct of stigma was to use Stigma Scale for Receiving Psychological Help (SSRPH). This measurement was adapted based on suggestions made by the helping professional who work with refugees in an agency. The reliability of the adapted measurement yields an unacceptable Cronbach's alpha among the study sample. The researcher decided to divide the measurement into two parts based on contemplating concepts and examining the Cronbach's alpha of the data. There were two concepts that had an acceptable reliability level: stigma towards socializing (one's attitude and beliefs) with people suffering from mental illness and stigma towards treatment-seeking individuals.

Stigma towards socializing. As noted in Table 4, a subscale stigma towards socializing with individual with mental health illness exhibited high internal consistency (Cronbach's α = .736). Therefore, the scores on the 4 items were averaged to generate a composite value to measure stigma towards socializing as Pinto, Hickman, and Thomas (2016) suggested.

Table 4

Internal Consistency of Stigma towards Socializing (N= 45)

Indicator (α=.738)	Mean	SD
I am willing to move next door to someone with a mental illness.	2.39	.895
I am willing to spend an evening socializing with someone with a mental illness.	2.14	.795
I am willing to make friends with someone with a mental illness.	2.16	.745
I am willing to have someone with a mental illness start working closely with me on a job.	2.16	.805

Stigma towards treatment-seeking. As noted in Table 5, a subscale mental health stigma towards treatment seeking individuals exhibited high internal consistency (Cronbach's α = .736). Therefore, the scores on the five-items were averaged to generate a composite value to measure the stigma toward treatment-seeking individuals as Pinto, Hickman, and Thomas (2016) suggested.

Table 5

Internal Consistency of Stigma Towards Treatment-seeking (N= 45)

Indicator (α=.795)	Mean	SD
Helping someone that is in distress, or experiencing a deep sadness is a good thing	2.82	0.84
Society needs to support those that have depression, and are struggling to cope with life	3.25	0.87
It is normal for people to face emotional challenges and seek professional help.	3.27	0.92
People that go to mental health professionals are strong, and are taking control of their lives	3.11	0.81
Moving to another country can cause a great deal of stress. Seeking out professional help is a positive move	2.84	0.86

Social Support Factor

As noted in Table 6, a subscale social support exhibited a high internal consistency (Cronbach's α = .948). Therefore, the scores on the 12 items were averaged to generate a composite value to measure social support as Zimet et al., (1988) suggested

Table 6

Internal Consistency of Social Support (N= 45)

Indicator (α=.948)	Mean	SD
There is a special person who is around when I am in need.	2.93	.818
There is a special person with whom I can share joys and sorrows.	2.75	.918
My family really tries to help me.	2.82	.896
I get the emotional help & support I need from my family.	2.93	.846
I have a special person who is a real source of comfort to me.	2.89	.841
My friends really try to help me	2.77	.886
I can count on my friends when things go wrong.	2.77	.803
I can talk about my problems with my family	2.82	.756
I have friends with whom I can share my joys and sorrows.	2.86	.795
There is a special person in my life who cares about my feelings	2.73	.788
My family is willing to help me make decisions.	2.70	.904
I can talk about my problems with my friends.	2.84	.805

Descriptive Statistics of Major Variables

This section presents the descriptive statistics of major variable. However, none of the respondents answered the question on "Monthly Income," so, information related to this variable is not provided. For the multiple linear regression analysis, other demographic factors would be considered.

Mental health formal help-seeking. Respondents were asked to indicate how likely they would be to seek help from a mental health professional, a phone help line, a doctor/general practitioner or other source not listed, or how likely they would be to not seek help from anyone. The summary of these statistics is found in Table 7. The responses were coded in a Likert scale format as follow: 1=extremely unlikely, 3=unlikely, 5=likely, 7=extremely likely. Mental health formal help seeking has been calculated by averaging the number of the first three items (Mental health professionals, Phone helpline, and Doctor/GP), as they are considered formal sources of mental health help. The results as presented in Table 7 indicated that the mean score for formal help

seeking was 2.81 (between extremely unlikely and extremely likely) with a standard

deviation of 1.17.

Table 7

Descriptive Statistics of Mental Health Formal Help Seeking (N=45)

	N	M	SD	SK	KT
Mental health professional (e.g., psychologist, social worker, counselor)	44	3.09	1.14	.21	2.54
Phone helpline (e.g., lifeline)	44	2.89	2.05	.76	-.76
Doctor/GP	43	2.47	1.82	.91	-.47
I would not seek help from anyone	43	5.07	1.99	-.725	-.60
I would seek help from another source not listed above (Please list in the space provided)	42	1.95	1.56	1.94	3.66
Formal Help-Seeking	45	2.81	1.17	.61	.06

Note. SK: Skewness, KT: Kurtosis.

Respondents who answered "other" (40%) identified different sources of

emotional and psychological help. Of those who identified other sources, 8.9% answered

that they would seek help from the IRC. The results also show that the other most

frequently reported source was "Friends" (4.4%). These specific results concur with what

Piwowarczyk et al. (2014) found in a study conducted on Congolese and Somali

refugees. According to these researchers, once mental health issues are identified, they

are first dealt within the communities with help of friends, family members or community

of faith in different ways (pastor, God, Bible, etc)

Table 8 below presents the means of all the factors included in this study. All the

variables were measured using a four-points Likert scale, 1=strongly disagree,

2=disagree, 3=agree and 4=strongly agree. These results indicate that social support has

the highest mean in the sample.

Table 8

Descriptive Statistics of Major Factors (N=45)

Variable	Min	Max	M	SD	SK	KT
Mental Health Knowledge	1	4	2.25	0.90	.09	-.83
Barriers to Mental Health Help-Seeking	1	4	2.39	0.62	.33	.27
Mental Health Stigma	1	4	2.58	0.45	-.32	4.47
Social Support	1	4	2.84	0.67	-.22	-.09

Note. SK: Skewness, KT: Kurtosis.

Hypothesis Testing

A multiple regression analysis was performed to test the following hypotheses:

- Hypothesis 1: Refugees who have a higher level of mental health stigma will seek less formal help for mental health issues.

- Hypothesis 2: Refugees who have a higher level of mental health knowledge will seek more formal help for mental health issues.

- Hypothesis 3: Refugees who have a higher level of social support will seek more formal help for mental health issues.

Prior to the multiple linear regression analysis, assumptions for testing a regression model were considered using Field's recommendation (2013). Multicollinearity problems (i.e., a high correlation between factors) were examined using the tolerance value for predictors (less than 0.2) or variance inflation factor (VIF) (10 or above). In addition, assumptions of normality of errors and linear regression were investigated. The examination of residual plots is considered a preferable method of

detection for the assumptions for linear regression including linearity and homoscedasticity (Field, 2013).

The initial regression model that includes all factors shows a multicollinearity due to a high correlation between barriers to mental health services access and MH Knowledge factors ($r=.762$). Another multiple linear regression analysis was conducted after Barrier to Help-Seeking, mean was eliminated. In Table 9, bivariate correlations among predictors are included in the revised regression model. The residual plot for this new regression model is presented in Figure 2, indicating the assumptions of linearity and equal variance were considered met. A statistical test of the normal distribution of the residuals showed that this assumption was also met (Shapiro-Wilk=.980, p=.614).
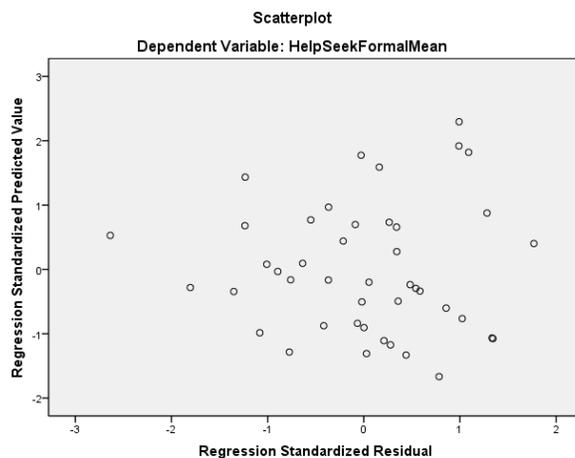
Figure 2: Residual plot for Mental Health Formal Help-Seeking

Table 9 presents the bivariate correlations among the factors included in this refined regression model.

Table 9

Bivariate Correlations among Predictors Included in the MLR

	1	2	3	4	5	6	7	8
1 Mental Health Formal Help-Seeking	1.00							
2 Gender	**.29**	1.00						
3 Education	**.48**	**.27**	1.00					
4 Stigma towards socializing	**.41**	**.23**	-.09	1.00				
5 Stigma towards treatment-seeking	**.42**	-.03	.21	**.38**	1.00			
6 Years in US	.100	.20	-.07	**.34**	**.38**	1.00		
7 Mental Health knowledge	**.63**	**.43**	**.53**	**.28**	**.39**	**.23**	1.00	
8 Social Support	**.27**	.13	.08	**.50**	**.54**	.16	**.25**	1.00

Note. Significant relationships between two continuous variables indicated by bold font

In order to examine the effect of each domain (demographic characteristics, mental health stigma, mental health knowledge, and social support) and each factor on the outcome, the regression was conducted with a hierarchical entry by adding each domain of factors consecutively to demographic factors. The regression model with 4 domains of 7 factors shown was statistically significant, explaining the variance of the outcome variable by 55.7%: $R^2 = .557$, Adjusted $R^2 = .471$, $F = 6.475$, $p < .001$).

Table 10

Multiple Linear Regressions of Mental Health Formal Help-Seeking(N=45)

Category	Factor	Model1	Model2	Model3	Model 4
		t	t	t	t
Demographic	Gender	1.224	.84	.10	.205
	Education	3.138*	3.26**	1.96	1.94*
Mental health Stigma	Stigma towards socializing[1]		2.72*	2.45*	2.57*
	Stigma towards treatment-seeking[2]		1.57	1.03	1.28
	Years in US		-.775	-1.02	-1.14
Knowledge	Mental health knowledge			2.37*	2.33*
Social Support	Social support				-.806
	ΔR^2	.262**	.219**	.069*	.008

*Note. R^2 =.557, Adjusted R^2 =.471, and F=6.475***; * $p < .05$, ** $p < .01$, *** $p < .001$
(1) Stigma towards socializing with individuals with mental illness
(2) Stigma towards treatment-seeking individuals

For each domain, the domain of mental health stigma with two factors (new addition in Model 2) was statistically significant, explaining the variance of the outcome variable by 21.9%: ΔR^2 =.219, ΔF=5.347, p = .004. [Hypothesis 1 supported] The domain of knowledge with one factor (new addition in Model 3) was statistically significant, explaining the variance of the outcome variable by 6.9%: ΔR^2 =.069, ΔF=5.631, p = .023. [Hypothesis 2 supported] The domain of social support with one factor (new addition in Model 4) was not statistically significant, explaining the variance of the outcome variable by 0.8%: ΔR^2 =.008, ΔF=.650, p = .426. [Hypothesis 3 not supported]

Model 4 in Table 10 presents the impact of each factor after controlling the effect of the rest of the factors included in the model. Out of 5 factors, 2 factors were statistically significant. The factor "Socializing with people with mental health issues" had the strongest association with the outcome: beta = .365, t = 2.567, p = .015). Refugees who held less stigma on mental health measured by the willingness to socialize with people who had mental health problems said that they would seek formal mental health help if they were having a personal and emotional problem. Mental Health Knowledge had a statistically significant association with the outcome: beta = .360, t = 2.332, p = .025). Refugees who had more knowledge about mental health reported that they would seek formal mental health treatment if they were having a personal and emotional problem. A control variable (Education) was statistically significant in Model 1 and Model 2, but this effect disappeared when the effect of Mental Health Knowledge was considered. A correlation between these two variables in table 10 (r=.529) shows that refugees who were more educated had more knowledge about mental health; therefore, they indicated that they would seek formal help for their personal and emotional problems.

CHAPTER V

DISCUSSION

The purpose of this study was to explore factors influencing refugees' mental health help-seeking. Previous studies have found that there is a high prevalence of mental health disorders among the refugee population, and a lower level of help-seeking for formal intervention (Piwowarczyk, Bishop, Yusuf, Mudymba, & Raj, 2014; Wachter et al., 2018). While this seems to be relevant for refugees from the Great Lacs Region of Africa who were resettled in the United States, the premise of this study is to answer the following research questions: Are refugees educated about mental health? Do refugees know about mental health services available in their community? What factors prevent refugees from seeking help for mental health issues? In doing so, a survey was conducted on 45 refugees who were resettled from Burundi, Democratic Republic of Congo, and Rwanda. As the results were subject to statistical tests, the present chapter intends to discuss the major findings.

Discussions of Major Findings

Mental health formal help-seeking is the dependent variable and it was measured using the General Help Seeking Questionnaire (GHSQ). The mean score for formal help-seeking from professional sources (e.g., psychologist, social worker, counselor) was 2.81 with SD=1.17 (between extremely unlikely and extremely likely). Less than a half of the respondents answered that they would seek help from a mental health professional if they

were having a personal and emotional problem such as loneliness, sadness, hopelessness, etc. This finding aligns with results of other studies that were conducted on refugees' mental health help seeking (Colucci, Valibhoy, Szwarc, Kaplan, & Minas, 2017; Fung & Wong, 2007; Mitschke, Praetorius, Kelly, Small, & Kim, 2017; Saint Arnault, Gang, & Woo, 2018).

Additionally, other studies (Lin, Inui, Kleinman, & Womack, 1982; Piwowarczyk et al., 2014) have confirmed that formal help-seeking for mental health issues may not be not the first resort in the general population . This indicates that formal help-seeking for mental health issues may be conditioned by different factors. Thus, in order to test the association between formal help-seeking variables and factors such as demographics, cultural barriers, knowledge barriers, and socioeconomic barriers, a multiple linear regression (MLR) was conducted. The initial regression model that included all factors (demographics, cultural barriers and knowledge) shows a higher correlation between "barriers to mental health help-seeking" and mental health knowledge ($r=.762$).

Significant Effect of Mental Health Stigma

In order to examine the effect of mental health stigma on the outcome (mental health formal help-seeking), a simple multiple linear regression was conducted. Mental health stigma was identified as the major construct for cultural factors subsequent to the literature reviewed. Thus, mental health stigma was categorized into two factors based on the items comprised in the measurement instrument used: stigma towards socializing with individuals with mental health issues and stigma towards treatment-seeking individuals Results indicated that the domain "mental health stigma" categorized into the two factors above mentioned was statistically significant. This indicates that refugees who were

willing to socialize with people experiencing mental health problems would seek formal mental health help. Additionally, respondents who had less stigma towards treatment seeking individuals would seek formal help for mental health issues.

This result may be partly explained by the modification of the measurement instrument used to assess the cultural belief factors operationalized under the mental health stigma variable. Because mental health has been identified as a topic that refugees could not discuss comfortably, the researcher was advised by professionals working with refugees to add positive statements to the scale (Stigma Scale for Receiving Psychological Help, SSRPH). Most of the respondents answered "strongly agree" to the positive statement newly inserted (items 9-14). This indicates that perceived stigma may decrease depending on how mental health issues are depicted. It is imperative to consider that this result concurs with researchers who posited that even though stigma was identified in research (Reynders, Kerkhof, Molenberghs, & Van Audenhove, 2014; Schomerus & Angermeyer, 2008; Wachter et al., 2018) as a major barrier, it may play a small role in explaining why refugees do not seek professional help for mental issues.

Effect of Mental Health Knowledge Factor

Results from the MLR indicates that mental health knowledge had a statistically significant association with the outcome. Refugees who had more knowledge about mental health reported that they would seek formal help if they were having a personal and emotional problem. Although the agency developed a new tool to measure the barriers to mental health services, this tool revealed a high correlation with the existing measurement (mental health knowledge factor). Although this new instrument was

excluded from the MLR analysis, it may be useful for the agency to identify specific areas of concern.

Effect of Social Support Factor

The researcher hypothesized that refugees with a higher level of social support barriers will be less likely to seek formal help for mental health issues. According to the results, social support was not a significant predictor of formal help seeking, explaining the variance of the outcome variable by 0.8%. While it was surprising that this result indicated that social support is not associated with formal help seeking, less than half of the respondents (40%) have identified friends, family members and faith related communities as other sources of help for mental health issues. Therefore, this result indicated that social support was not a predictor of formal help seeking for mental health issues. The results also aligned with what Mitschke et al. (2017) found in a qualitative study they conducted on refugees. These authors posited that refugees who had a strong sense of community tended to confide in community members, family, friends, or God through prayers if they needed emotional and psychological support. Overall, based on the results at hand, refugees who have a stronger social support would not seek professional help for mental health issues for fears of being stigmatized within the community.

<div align="center">

Implications of Findings

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Implications for Practice

There are numerous vital implications for practice in the delivery of mental health-related services to refugees from the Great Lacs Region of Africa. Social workers and other mental health professionals' best practice is to embrace a client-centered

approach to mental health care. Falk-Rafael (2001) posits that the best way of taking this approach is to meet the clients where they are. Thus, the present study exploring factors influencing refugees' mental health help-seeking may inform practitioners about where refugees are, regarding seeking formal help for mental health-related issues.

The results have indicated that mental health knowledge was associated with formal help-seeking. Therefore, as have found in the literature reviewed, the need for this knowledge is not solely limited to refugees who need mental health services. As refugees from Congo, Burundi, and Rwanda constitute a growing population in the City of Abilene, mental health providers need a global understanding of culture and beliefs around mental health as perceived by refugees and providers. This study and other research that was conducted have highlighted a shortcoming in mental health services delivery to this diverse population. Nevertheless, if being well equipped in mental health knowledge would bridge this gap, mental health professionals are challenged by this result. In as much as refugees from the Great Lacs Region of Africa need to be educated about common mental health disorder, occurrences, symptoms and available resources for treatment, mental health service providers need to understand the cultural background, myths, and facts about these refugees' conceptions towards mental health issues. In doing so, the selection of an appropriate, and culturally competent screening tool would be ensured.

Additionally, mental health formal help-seeking was associated with stigma. Not only is there a need for mental health service deliverers to be aware of this phenomenon, but also to look for patterns in those who are already receiving services and who were not able to keep up with the treatment plan. This would allow better planning for retention of

care by encouraging discussion about stigma with the client. This study would be beneficial for mental health practitioners, especially those who provide counseling services, to work closely with resettlement agencies to improve refugees' access to services. The results of the present study would encourage the routine screening and referral process to be accompanied by an individualized intervention targeting identified factors hampering intentions for help-seeking. For refugees, this study implies the need to increase awareness about formal help-seeking for mental health-related problems.

Implications for Policy

The CDC encourages refugees' screening before they come to the US under the resettlement process. The CDC recommends taking the screening opportunity to educate refugees about mental health issues and expected stress responses in the new country where they are resettled. The results of the present study align with this recommendation. Clear policies are needed to guide the design of a comprehensive tool instrument that would be used to educate refugees about common mental health issues. In short, this study could be used to facilitate action plans for the delivery of mental health services to refugees in the course of the resettlement process.

Limitations of the Study and Implications for Research

The current study focuses on refugees' mental health help-seeking, and it has several limitations worth considering while appraising the findings. The primary weakness is the small size sample. While 63 respondents consented to participate in the study, only 45 were able to take the survey up to completion. While this number (45) of respondents seems to be reasonable, considering the time and financial constraints, it is

not representative of all the refugee population resettled in Abilene, Texas. Therefore, the results could not be generalized to another refugee populations.

Additionally, this study is exploratory with a cross-sectional design. The main limitation of this design is that no causal relationship between variables can be proven. The only possible connection might be attributed to the association or correlation between the identified variable and the outcome variable since no experiment was conducted. This said, the findings from this study are not enough to make a claim that refugees will seek formal help for their mental health problems if they were well educated about the occurrences and specificities of those problems.

Another major limitation was the language barrier. Most of the refugee population targeted by this study are not proficient in the English language, so the researcher provided a translated version of the survey in the two main languages spoken by the respondents. Not only was it difficult to find the exact/equivalent translation for the concept of mental health, but, the translated version was lengthy due to the additional explanation that was needed for clarification. Moreover, the Likert model used was complicated and confusing the respondent as there was no direct translation for "strongly agree and strongly disagree."

Some of the respondents were unable to read and write their native languages. To be able to take the survey, they needed assistance. The researcher assumed the responsibility to assist the respondent who consented to take the survey and who could not read and write. This responsibility had a twofold impact. First, on the overall process, it was time-consuming to read the question/statements to the respondents and make sure they understood before deciding what option to select. This affected the number of

respondents who participated, considering the limited time that the researcher had to collect data. Second, unlike other self-administered surveys, this procedure may be highly prone to social desirability. Therefore, reliability of the responses was compromised.

The researcher's biases towards refugees' mental health constituted another limitation. Firstly, the choice of topic was motivated by personal experiences. It was difficult, to some extent, to dissociate refugees' mental health myths from the facts. It was especially difficult to ignore the realities already known about mental health issues among the population under study.

Based on the findings of this study and previous research conducted in this field, mental health knowledge and cultural barriers have a statistically significant relationship with mental health formal help-seeking. Further research could be done about where, when, how and what strategies are most active and evidence-based to provide this knowledge to refugees from the Great Lacs Regions of Africa to boost their help-seeking intentions and behaviors. Additionally, subsequent qualitative research could add more understanding to the results of the present study. Specifically, the fact that social support was found not to be a predictor for formal help-seeking for mental health issues needs to be more investigated. Different qualitative studies, namely, (Dubus, 2018; Wachter & Gulbas, 2018) have shown that the loss of social support may increase depression among newly resettled refugees.

Due to time constraints, this study did not include mental health service providers and refugees' communities including local churches. However, mental health formal help-seeking always involves a relationship between a service provider and a receiver and

a population of the service receiver. Thus, one study that would be immensely beneficial would include all three stakeholders mentioned above in refugees' mental health services.

Finally, this study did not explore factors associated with formal help-seeking for a specific mental health issue. While the factors identified in the literature as independent variables in this study should not be ignored, further studies should research whether they should be targeted to bring awareness to refugees struggling with mental health issues. Also, supplementary research focusing on specific mental health disorder such as major depressions disorders, schizophrenia, bipolar disorders, substance use disorders, and so on, are needed among refugees from the Great Lacs Region of Africa.

Conclusion

Refugees from the Great Lacs Region of Africa are at a higher risk for mental health disorders. This part of the African continent has experienced ethnopolitical conflicts for several years, which has led some of the inhabitants to flee their home countries. Losing one's home, belongings, and loved ones negatively affects an individual's physical, emotional and psychological being. Before the resettlement journey, refugees' effective way of coping was resilience, mainly due to a scarcity of mental health resources.

In addition to scars of war that may be hidden under the joys and excitement of finding a haven, refugees in the resettlement process encounter other life stressors. While refugees who are resettled in the U.S. may still carry the burdens imposed by war trauma, very few seek formal help when they are experiencing a mental health issue. This study explored the factors that hindered refugees from seeking help from mental health professionals. The goal of this study was to find out if mental health knowledge barriers,

cultural barriers, and socioeconomic barriers were associated with mental health formal help-seeking.

This quantitative exploratory study used survey questions to gather necessary information about the aforementioned mental health predictors. The results of the analysis have shown that refugees who have knowledge about mental health, and those who held less stigma towards people with mental health issues are likely to seek formal help. These results suggest a vital need to educate refugees from Burundi, Democratic Republic of Congo, and Rwanda about mental health issues and where to get formal services. This education should be coupled with researching, designing and testing culturally sensitive interventions that would aim to reduce the stigma around mental health in this population.

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APPENDIX A

IRB Approval Letter

ABILENE CHRISTIAN UNIVERSITY
Educating Students for Christian Service and Leadership Throughout the World

Office of Research and Sponsored Programs
320 Hardin Administration Building, ACU Box 29103, Abilene, Texas 79699-9103
325-674-2885

January 3, 2019

Frediane Ndikumana

Department of Social Work

Abilene Christian University

Dear Frediane,

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled "Exploring Factors Influencing Refugees' Mental Health Help-Seeking",

(IRB# 18-137   )is exempt from review under Federal Policy for the Protection of Human Subjects.

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

Megan Roth

Megan Roth, Ph.D.
Director of Research and Sponsored Programs

APPENDIX B

Informed Consent to Participate in a Study

Title of Study: Exploring Factors that Influence Refugees' Mental Health Help- Seeking

You may be eligible to take part in a research study. This form provides important

information about that study, including the risks and benefits to you, the potential

participant. Please read this form carefully and ask any questions that you may have

regarding the procedures, your involvement, and any risks or benefits you may

experience. Also, please note that your participation is entirely voluntary. You may

decline to participate or withdraw from the study at any time and for any reason without

any penalty or loss of benefits to which you are otherwise entitled.

Please contact the Principal Investigator if you have any questions or concerns regarding

this study. This contact information may be found at the end of this form.

Purpose and procedures.

You are invited to participate in this study that explores the factors influencing refugees'

mental health help seeking. You will be asked to rate: (1) your level of mental health

knowledge barriers, (2) cultural belief barriers and (3) socioeconomic barriers to mental

health seeking for professional intervention. This research is designed to see if these

factors are associated with mental health help seeking among refugees from the Great

Lacs Regions. Once you consent to participate to this study, you will be asked to

complete a survey that should take approximately 15 minutes.

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Risks and discomforts

This is not an IRC research project; therefore, your participation will not affect in any services that you were receiving or entitled to receive from the IRC. The primary risk with this study is a breach of confidentiality. The researchers have taken steps to minimize the risks associated with this study. You will not be asked for any identifying information such as your name, address and contact number to further protect your identity. However, if you experience any problems, you may contact the Principal Investigator Frediane Ndikumana at nxf17a@acu.edu. Mental health topic may trigger stress responses and discomfort in those who have experienced or have their beloved ones experiencing mental health issues. Some of the survey questions may cause mild to severe emotional distress. If anxious or depressive symptoms increase, please seek assistance from a qualified medical professional.

Potential benefits

 There are potential benefits to participating in this study. Such benefits may include a better understanding of mental health related issues and resources available. The researcher cannot guarantee that you will receive any personal benefits from participating in this study. However, the researcher hopes that the information learned from this study, and the results that will be generated will help participants and future refugees to deal with mental health issues. There are potential benefits to participating in this study. Such benefits may include an increased awareness of mental health issues, how those issues may have an impact on reaching self-sufficiency, as well as on the daily functioning.

Provisions for confidentiality

Information collected about you will be handled in a confidential manner in accordance with the law. Participant personal identity will not be requested. If the information received needs to be released, for any reason, the participant will be informed.

Contact. If you have any questions, concerns, or comments, you may contact the Principal Investigator of this study. The Principal Investigator is:

Frediane Ndikumana, MSSW Candidate

(325) 260-1069

Nxf17a@acu.edu

ACU Box 27866, Abilene, TX, 79699

If you are unable to reach the Principal Investigator or wish to speak to someone other than the Principal Investigator, you may contact the faculty supervisor:

Kyeonghee Jang, PhD, LMSW

325-674-6428

khj15a@acu.edu

ACU Box 27866, Abilene, TX 79699

If you have concerns about this study or general questions about your rights as a research participant, you may contact ACU's Chair of the Institutional Review Board and Director of the Office of Research and Sponsored Programs, Megan Roth, Ph.D. Dr. Roth may be reached at

(325) 674-2885

megan.roth@acu.edu

320 Hardin Administration Bldg, ACU Box 29103

Abilene, TX 79699

I have read and understand the information written above and understand that

participation is voluntary and that refusal to participate will not penalize me in any way. I

acknowledge that I have received a copy of this consent translated in my native language.

Signature _____   Date: _____

APPENDIX C

Informed Consent : Swahili Translation

Ruhusa ya kukubali kushiriki katika utafiti

Unaweza kustahili kushiriki katika utafiti wa utafiti. Fomu hii hutoa taarifa muhimu

kuhusu utafiti huo, ikiwa ni pamoja na hatari na faida kwako, mshiriki anayeweza.

Tafadhali soma fomu hii kwa makini na uulize maswali yoyote ambayo unaweza kuwa

nayo kuhusu taratibu, ushirikishwaji wako, na hatari yoyote au faida ambazo unaweza

kupata. Pia, tafadhali angalia kuwa ushiriki wako ni kikamilifu kwa hiari. Unaweza

kukataa kushiriki au kujiondoa kwenye utafiti wakati wowote na kwa sababu yoyote bila

adhabu au kupoteza faida ambazo wewe hakika una haki.Tafadhali wasiliana na

Mpelelezi Mkuu ikiwa una maswali yoyote au wasiwasi kuhusu utafiti huu. Maelezo ya

mawasiliano haya yanaweza kupatikana mwishoni mwa fomu hii.

Kusudi na Utaratibu

Unaalikwa kushiriki katika utafiti huu unaozingatia sababu zinazoathiri kutafuta msaada

wa afya ya wakimbizi. Utaulizwa kuzingatia: (1) kiwango chako cha ukosefu wa vikwazo

vya elimu ya afya ya akili, (2) vikwazo vya imani na kitamaduni na (3) vikwazo vya

kijamii kwa afya ya akili kutafuta uingiliaji wa kitaaluma. Utafiti huu umeundwa ili

kuona kama mambo haya yanahusishwa na msaada wa afya ya akili katika miongoni

mwa wakimbizi kutoka Mikoa Mkubwa ya Maziwa. Mara unapokubali kushiriki katika

utafiti huu, utaulizwa kukamilisha uchunguzi ambao unapaswa kuchukua muda wa

dakika 15.

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Hatari na kuharibika

 Hatari kuu kwa utafiti huu ni uvunjaji wa siri. Watafiti wamechukua hatua za kupunguza

hatari zinazohusiana na utafiti huu. Hutatakiwa habari yoyote ya kutambua kama vile jina

lako, anwani na namba ya kuwasiliana ili kulinda zaidi utambulisho wako. Hata hivyo,

ikiwa una matatizo yoyote, unaweza kuwasiliana na Mpelelezi Mkuu Frediane

Ndikumana kwenye nxf17a@acu.edu. Mada ya afya ya akili inaweza kusababisha majibu

ya wasiwasi na wasiwasi kwa wale walio na uzoefu au kuwa na wapendwao wanao na

matatizo ya afya ya akili. Baadhi ya maswali ya uchunguzi yanaweza kusababisha shida

kali ya kihisia. Ikiwa ongezeko la dalili za wasiwasi au za kuumiza, tafadhali tafuta

msaada kutoka kwa mtaalamu wa matibabu.

Faida za uwezekano

 Kuna faida nzuri ya kushiriki katika utafiti huu. Faida hizo zinaweza kujumuisha

ufahamu bora wa masuala ya afya ya akili na rasilimali zilizopo. Mtafiti hawezi

kuthibitisha kwamba utapokea faida yoyote binafsi kutokana na kushiriki katika utafiti

huu. Hata hivyo, mtafiti anatarajia kuwa habari zilizojifunza kutoka kwa utafiti huu, na

matokeo ambayo yatazalishwa itasaidia washiriki na wakimbizi wa siku za nyuma

kukabiliana na masuala ya afya ya akili.

Kuna faida nzuri ya kushiriki katika utafiti huu. Faida hizo zinaweza kujumuisha uelewa

wa kuongezeka kwa masuala ya afya ya akili, jinsi masuala hayo yanaweza kuwa na

athari za kufikia uwezo wa kujitegemea, pamoja na kazi ya kila siku.

Mipango ya usiri

Habari zilizokusanywa kuhusu wewe zitashughulikiwa kwa siri kwa mujibu wa sheria.

Utambulisho wa kibinafsi wa washiriki hauwezi kuombwa. Ikiwa maelezo

yaliyopokelewa yanahitaji kufunguliwa, kwa sababu yoyote, mshiriki huyo atatambuliwa.

Wasiliana

Ikiwa una maswali yoyote, wasiwasi, au maoni, unaweza kuwasiliana na Mpelelezi

Mkuu wa utafiti huu. Mtafiti Mkuu ni:

Frediane Ndikumana, Msajili wa MSSW

(325) 260-1069

Nxf17a@acu.edu

ACU Box 27866, Abilene, TX, 79699

Ikiwa huwezi kufikia Mpelelezi Mkuu au unataka kuzungumza na mtu mwingine

isipokuwa Mpelelezi Mkuu, unaweza kuwasiliana na msimamizi wa kitivo:

Kyeonghee Jang, PhD, LMSW

325-674-6428

khj15a@acu.edu

ACU Box 27866, Abilene, TX 79699

Ikiwa una wasiwasi juu ya utafiti huu au maswali ya jumla juu ya haki zako kama

mshiriki wa utafiti, unaweza kuwasiliana na Mwenyekiti wa ACU wa Bodi ya Uhakiki

wa Taasisi na Mkurugenzi wa Ofisi ya Utafiti na Programu Zilizoidhinishwa, Megan

Roth, Ph.D. Dk Roth inaweza kufikiwa saa

(325) 674-2885

megan.roth@acu.edu

320 Hardin Utawala Bldg, ACU Box 29103

Abilene, TX 79699

Nimesoma na kuelewa habari zilizoandikwa hapo juu na kuelewa kuwa ushiriki ni wa

hiari na kukataa kushirikiana haitafanya penalize mimi kwa njia yoyote.

Saini _____ Tarehe: _____

APPENDIX D

Survey Questions

For the context of this survey, mental health is defined as the state of emotions and physical/psychological state people experience as a result of trauma. Mental Health stressors may include isolation, feeling of helplessness, other physical health condition, and so on.

Demographic Information

    A. Gender (Please mark what is applicable)

1) Male
2) Female
3) Transgender
4) Prefer not to answer

    B. Marital status

1) Single
2) Married
3) Widowed
4) Divorced

    C. Country of Origin

1) Burundi
2) DRC
3) Rwanda

    D. How long have you been in the U.S.?

1) 1 to 3 years
2) 3 to 5years

3) 5 to 8 years

4) 8 to 10 years

    E. Education

1) No formal Education

2) Primary School

3) Secondary school

4) Vocational education

5) Baccalaureate degree

6) University degree

7) Master's degree

    F. What is your monthly income?

1) $0 to $1000

2) $1001-$2000

3) $2001 - $3000

4) $3001 - $4000

5) $4001- $5000

6) $5001+

    G. Does your health insurance cover mental health services?

1) Medicaid

2) Medicare

3) Insurance from the employer

4) No insurance at all

Formal Mental Health Help**-Seeking**

If you were having a personal and emotional problem (such as loneliness, feeling very sad, feelings of hopelessness etc.), how likely is it that you would seek help from the following people?

1=Extremely unlikely 3=Unlikely 5=Likely   7=Extremely Likely

1. Mental health professional (e.g., psychologist, social worker, counselor)	1	2	3	4	5	6	7
2. Phone helpline (e.g., lifeline)	1	2	3	4	5	6	7
3. Doctor/GP	1	2	3	4	5	6	7
4. I would not seek help from anyone	1	2	3	4	5	6	7
5. Other (Please indicate in the space below) _____	1	2	3	4	5	6	7

Mental Health Knowledge

Please indicate to what extent you agree with the following statements:

	1.Strongly Disagree	2.Disagree	3. Agree	4. Strongly Agree
1.I able to recognize symptoms of a mental disorder				
2.I am confident that I know where to seek information about mental illness				
3.I am confident using the computer or telephone to seek information about mental illness				
4.I am confident I have access to resources (e.g., General Practitioner, internet, friends) that I can use to seek information about mental illness				
5.I am confident attending face to face appointments to seek information about				

	mental illness (e.g., seeing the General Practitioner)			

Barriers to Mental Health Services

Please indicate to what extent you agree with the following statements**:**

	1. Strongly Disagree	2. Disagree	3. Agree	4. Strongly Agree
1.I know how to ask for an interpreter at appointments				
2.I have access to transportation to health/mental health appointments.				
3.When someone talks about Mental Health, I understand what they mean.				
4.I have sufficient income to pay for Mental Health Services.				
5.My insurance would cover Mental Health services.				
6.I feel comfortable sharing emotional struggles in my community.				
7.I have the time I need to see a medical professional (I can take time off work, I have someone to watch my children etc.)				

Mental Health Stigma

Please indicate to what extent you agree with the following statements

	1. Strongly Disagree	2. Disagree	3. Agree	4. Strongly Agree
1.I am willing to move next door to someone with a mental illness?				
2.I am willing to spend an evening socializing with someone with a mental illness?				
3.I am willing to make friends with someone with a mental illness?				
4.I am willing to have someone with a mental illness start working closely with me on a job				
5. Most people struggle in some ways, or experience loneliness.				
6. Helping someone that is in distress, or experience deep sadness is a good thing				
7. Society needs to support those that have depression, and are struggling to cope with life				
8. It is normal for people to face emotional challenges and seek professional help.				

9. People with mental illness can fully contribute to society				
10. Moving to another country can cause a great deal of stress. Seeking out professional help is a positive move				

Social Support

Please indicate how you feel about each statement below.

	1.Strongly Disagree	2.Disagree	3.Agree	4.Strongly Agree
1.There is a special person who is around when I am in need.				
2.There is a special person with whom I can share joys and sorrows.				
3.My family really tries to help me.				
4.I get the emotional help & support I need from my family.				
5.I have a special person who is a real source of comfort to me.				

6.My friends really try to help me				
7.I can count on my friends when things go wrong.				
8.I can talk about my problems with my family				
9.I have friends with whom I can share my joys and sorrows.				
10.There is a special person in my life who cares about my feelings				
11.My family is willing to help me make decisions				
12.I can talk about my problems with my friends.				