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Mental Health Among Somali Women in the United States

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By

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Abstract

This study examined depression, stress, and anxiety and explored the complex factors that may influence Somali women's psychological well-being. The study surveyed 53 subjects identified as Somali women aged 18 to 69 years old living in a major Metropolitan area in the Upper Midwest United States. Three research questions focused on investigating whether a depressed mood correlates with the severity of trauma, identifying what causes elevated anxiety, and assessing the significance of stress among Somali women.

This research was critical to identify the mental health perceptions and the obstacles these women may have. The surveyed subjects reported severe depression mood, including changes in sleeping patterns, appetite changes, tiredness or fatigue, and loss of interest of higher severity, which highlighted the significant emotional distress and depressive symptoms experienced by this group. On moderate stress and elevated anxiety, the study also found moderately high frustration related to being unable to support oneself financially and worrying about family members who were separated, with some individuals deeply affected by the separation. The sadness of not reuniting with their family members was common, underscoring the emotional toll of such circumstances. This quantitative study extends the research on Somali women's mental health by utilizing a quantitative measure of depression, stress, and anxiety while focusing on additional factors, including cultural stigmas and community integration, which are widely under-researched. Future research can provide a more comprehensive understanding of depression, stress, and anxiety among Somali women and contribute to the development of effective interventions and policies to support their mental health.

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TABLE OF CONTENTS

List of Figures

CHAPTER I

INTRODUCTION

Mental health illnesses are the most common problems facing refugees running away from wars and other violent scenes. Many refugees have long-lasting, extremely stressful, and traumatic events within their lifetimes because of their experiences of different events, including fighting, cruelty, torture, sexual violence, and natural disasters (Onyut et al., 2009). Women suffer unduly during and after the wars, and most of the time, they are mistreated by all sides of the conflict compared to men (United Nations, 2003). In Somalia, as in any other conflict area, women experience war-related traumatic events and become vulnerable to violence against them because of their gender (United Nations, 2003).

In refugee camps, according to Crisp, J. (2000), many women cannot feed, clothe, and shelter themselves and their children and become susceptible to physical and sexual exploitation and other abuses to get food and shelter for their families. In addition, women and girls in the refugee camps also experience arranged marriages and rape by their refugee males. Næss (2019) suggested that social isolation, family responsibility, loss of loved ones, and the hardship of being refugees in overcrowded camps with few services can be strongly associated with mental and physical health complications. In addition, depression and anxiety are higher for people who have experienced traumas and mostly lack interest in persuading professional mental health services or become unwilling to accept diagnoses and treatments (Næss, 2019).

Background of the Problem

Somalia has a history of centuries of conflict relating to territories, kingdoms, sultanates, colonial, military rule, and the latest clan-based rules. On the other hand, the Somali regions in East Africa share one culture, one religion, and the Somali language. Somalia's blue flag with the white star represents the northern and southern regions of present Somalia, the northeastern province of Kenya (NFD), the Ogaden province of Ethiopia, and Djibouti (Laitin, 1976). Somalis in these regions and beyond belong to a clan system, which is an agnatic and stratified structure centered around the everyday lives of Somalis. This shared identity is categorized into subgroups with genealogy and linkage to a single male ancestor. In the community, the clan system serves as the foundation of unity. It also influences every Somali individual and social life, which is more important than individual matters (Griffiths, 1997).

The clan system, a cornerstone of Somali culture, plays a pivotal role in shaping social relations and maintaining social harmony. It is a hierarchical structure that dignifies the common good for the whole community and is essential for fostering clan and family strength. In Somali culture, kinfolk is the source of unity and the primary mediator in conflicts and social structure. The role of clanship is the primary basis of social relations among Somalis. The clanship is typically analyzed as a standard feature of social structure, an objective system of social relations. "Somalis' clanship is an element of 'traditional' social structure and can be regarded as a focal point for renegotiating identity for those living in exile" (Griffiths, 1997, p.5). The clan system is a preventive rule to protect members from inside and outside interests. It also serves as a mechanism for conflict resolution, with the clan rules affecting not only a personal choice

but the lives of every member of the Somali community. Also, its social measures constrain each affiliate's dealings with others, family members, and other societies.

History of the Somali People and Conflicts

Soon after the military rule took over the civilian government in 1969, Somalia went to war with Ethiopia in 1977, and in late 1978, Somali armed groups started fighting with the government, leading to the collapse of Somalia's central government in 1991(Barnes, 2006). This sequence of conflicts created decades of suffering and massive internal and external displacement, which has created many psychological and physical catastrophes among the Somali people (Hammond, 2014). Since the central government's collapse, the world has viewed Somalia as an ongoing violence and displacement scene.

Somalia also hosts refugees and other drought-displaced communities with different stages. For example, from 1977 to 1978, Somalia hosted an "estimated 650,000 Ethiopian Somali refugees who were fleeing the Somalia-Ethiopia border war" (Hammond, 2014, p.1). Most of these families lived within the disputed boundary where intense combat was. In addition, from the late 1970s until the early 1980s, thousands of Somalis from the northern part of the country, known as Puntland and Somaliland, were exposed to extreme violence from the former dictatorship government in Somalia (Metz, 1993). The violence against these regions, including torture, rape, and killing of civilians, has caused massive displacement and traumatic experiences (Metz, 1993).

Mental Health

After escaping Somalia's civil war, thousands of Somalis sought sanctuary in refugee camps in neighboring countries with their children, while some left behind their husbands and sons and never saw them again (Neuner, 2004). Stressful life events like

conflicts, displacement, living in refugee camps, and sexual violence can lead refugees to experience mental health problems. A study conducted in Uganda's refugee camp has found that the Somali refugees there had experienced more psychological and emotional problems and scored higher on the prolonged grief disorder symptoms than other refugees in the camp. They also "scored higher on separate post-traumatic stress disorder symptoms" (Onyut et al., 2009, p. 6). The study found that depression and anxiety related to the conflict and refugee experiences remain very high among Somali refugees. However, such conditions disproportionately affect women who witnessed the indiscriminately killing of husbands, sons, and other family members while witnessing other atrocities. In addition, Somali women had shown experiences of more past and current traumatic symptoms than other women. Many of these women avoid social interaction due to profound anxiety and depression (Onyut et al., 2009).

Jorgenson et al. (2021) found that post-migration living difficulties, such as resettlement adjustment problems, can add to the early effects of conflict trauma refugees are already experiencing. Lacour et al. (2020) found that post-immigration living difficulties and varying social, political, and economic circumstances might differ from one accommodating country to another. For example, refugees who have a secure legal status and receive psychological treatment in Switzerland are more worried about the isolation, situations in their homeland, and family instead of anxiety about their safety or desires (Lacour et al., 2020). People who fled from war zones drastically increased many risks for mental health issues, which may signal irregular actions that may worsen their ability to manage social and family life (Lacour et al., 2020).

In addition, when immigrants arrive in new and unfamiliar environments, they adapt to a new culture, often resulting in psychological and social challenges (Crow, 2012). This assimilation involves the interaction and integration of different cultural groups, and it can cause different stressors that influence the health of individuals revolving around this challenging journey. According to Crow (2012), the consequence of this integration may set stressful behaviors "that include anxiety, depression, feelings of marginality and alienation, heightened psychosomatic symptoms, identity confusion" (pp. 153–154), as well as feelings of isolation and a sense of loss. The interaction of these influences can lead to increased acculturation stress, a term encompassing the psychological and emotional tension individuals experience as they strive to balance their original cultural identity with the demands of the new culture (Betancourt et al., 2015). As people engage in a new cultural environment, they may encounter challenges related to language barriers, social norms, values, and unfamiliar societal structures. (Betancourt et al., 2015). Limited mental health services may further exacerbate these challenges, creating barriers to seeking and receiving appropriate support.

Jorden et al. (2009) measured the relationship between wartime experience, social adjustment, and emotional grief among refugees. "Many participants had encountered some form of collective trauma, in particular, exposure to warfare and ethnic discrimination events often occurred prior to leaving Somalia" (Jorden et al., 2009, p.86). Although the most common traumatic experience described by refugees was the death of a loved one, individuals experiencing the stress of acculturation say that family pressure, loss of status, discrimination, and language barriers were the reasons for their depression. On the other hand, there is an indication that more women suffer from depression than

men and do not seek help due to their fear of being stigmatized (Shannon, 2014). For example, Somalis often call a person with a mental illness "insane," This stigma can prevent many people with mental illness from seeking professional help. Furthermore, minimal data on mental health among Somali women in the United States is available.

Traditional and Religious Practices

Commonly, Somalis do not know mental illness signs and perceive a mentally ill person negatively because there is no concept of mental illness in Somali culture. Instead, many Somalis believe mental illness's roots are spirit possession, witchcraft, or evil eye (Ibrahim et al., 2022). In addition, social rejection, shame, embarrassment, and discrimination might inspire the sick to reach only trusted traditional healers instead of professional services (Johnsdotter et al., 2011). In the community, traditional healers are perceived as more trustworthy and sympathetic to people with mental health problems towards their cultural perspective. Furthermore, the mental illness stigma impacts sick people and their families, who might feel humiliated because of the illnesses. It means loneliness, and the sick person's family often plays an unhelpful role in seeking professional help. There were some mental health facilities in Somalia, even though the concept was culturally foreign.

However, most mentally sick patients were held at home, confined, and secured by a chain to safeguard people from potential acts of violence and improper actions, or sometimes people harassing the mentally sick person (Bettmann et al., 2015). In addition, during and after treatment, families play a critical role by providing physical, psychological, and spiritual care for the ill person and facilitating all dealings with the healers (Padela et al., 2012). Although Somalis typically consider traditional healing

practices for treating the mentally ill, Islamic values and cultural healing are also fundamental to Somali identities and culture. Ahmed & Puglielli (1988) societies characterize traditional healers as intercessors and their spiritual world. These traditional healers did not only treat illness, but they were spiritualists who could solve all kinds of societal complications. They are self-assured and influenced to encourage sick people to have adequate tolerance to understand their obstacles. Because of this understanding and trust in their patients, many people refer their health issues to traditional healers (Ahmed & Puglielli, 1988).

Islamic healing is one of the fundamental approaches to dealing with health issues, and "being religious increases patients' satisfaction and treatment adherence" (Sabry & Vohra, 2013, p. 207). Muslims believe that the Holy Quran offers a divine direction to treat any disease, and Quranic readings and prayers are crucial methods of dealing with mental health illnesses (Zoellner et al., 2021). In many countries, Islamic centers are helping those suffering from mental health and other sicknesses by using different techniques to treat or guide mental health patients, including counseling, reciting parties of the Quran, and giving holy water. Sabry & Vohra (2013) Islam plays an essential role in managing negative social experiences that may have a psychological impact on individuals' well-being, and Islamic counseling is one of the strategies that help with prevention and treatment.

Barriers and Services for Somali Women

Mental illness stigmatization can be found in many cultures and might prevent people with the illness from seeking professional treatment (Ahmed & Puglielli, 1988). In some cultures, a sick person's gender can play a role, especially in how societies react to

individuals' mental health problems, and traditional gender principles can also create barriers (Næss,2019). For example, Somali immigrant women in Norway may have lower mental health service use than Somali men. In addition, Somali women's symbolic association with family accentuates perceived stigma and might contribute to collective and individual concealments. Additionally, Somali women's cultural obligations and views within the family add to both collective and self-initiated strategies for mental health problem concealment (Næss, 2019).

Usually, Somalis do not talk about mental health illnesses in public, making it difficult for individuals trying to seek help, especially women, who try to get treatment because of cultural pressure (Ahmed & Puglielli, 1988). The other obstacle is that many people with mental health patients often contradict their disease and blame their sickness, spirit possession, or evil eye (Ibrahim et al., 2022). Mental disease repudiation, gender obligation, and safeguarding social values and family reputations might raise the opportunities not to seek and accept mental-health services for Somali women (Ibrahim et al., 2022). For many Somali women, the isolated environment they encounter in their adopted new countries makes them more likely to raise signs of depression and anxiety than women who have not experienced displacement or wars. Some Somali refugee women believe that mental "illness had stronger roots in explanations such as spiritual dissonance, social disconnection, and sadness" (Pavlish et al., 2010, p.355).

Many Somali women may experience multiple traumas and have had a long-term impact of this trauma during the war and while residing in their host countries. In addition, Somali women may experience more depression and anxiety while in the host nations because of a lack of social integration. Somali women were very socially active in their

homeland and always had commonality, connections, trust, and support from their female family members, neighbors, and other social networks (Guerin et al., 2006). Neighborhood gatherings, female nights out, and weddings were the typical social interaction experiences for the women.

However, after resettling to countries with different cultures and norms, their social relationship bonds with other Somali women have vanished (Guerin et al., 2006). Many women become more isolated than ever while experiencing different distresses and frustration. Research by McMichael and Manderson (2004) found that the physical and collective circumstances of the settlement of Somalis in a new environment can make it very difficult to build the same social relationships they have in their homeland. Because their new lives now define the means they can share with their relatives and friends and the level of interactions that can occur because of their busy lives (Barker, 2021). Most immigrants often lose some characteristics of their social integration. It becomes hard to form the same social networks they used to have or develop a sense of belonging because of the Western social routines, economics, language, and other barriers.

Awareness and Access

The inadequacy of mental health knowledge, lack of proper interaction with the community, and the accessibility of mental health care services prevent refugee communities from seeking help and increase negative views towards mental illness stigma (Wei et al., 2015). Mental health literacy is an important tool for developing a community understanding of health issues awareness because it is the aptitude to increase accessibility and influences people to understand and construct successful habits of healing knowledge to comprehend and follow treatments (Jorm et al., 1997). Mental

health literacy develops an awareness strategy to decrease stigma and change negative behaviors toward mental illness. Like many communities, Somalis lack consistent and accurate knowledge about mental health services, and the stigma of hiding the illness prevents many women from seeking proper treatment. Furthermore, Wei et al. (2015) suggested that mental health literacy will likely increase personal and community health awareness.

Purpose Statement

The purpose of the study is to explore Somali women's depression, stress, and anxiety to gain an inclusive understanding of the unique challenges and mental health struggles faced by these vulnerable populations. It also aims to examine the factors contributing to their psychological distress. The study aims to inform targeted interventions, support systems, and policies that can effectively address and alleviate the mental health burden experienced by Somali women in the United States.

Hypotheses

This study investigated whether depressed mood correlates with the severity of trauma among Somali women in the United States. Thus, the causes of depression among Somali women were examined (Abdi et al., 2022). As Venters & Gany (2009) demonstrated, immigrants who may have experienced life-threatening trauma before migrating to Western nations may develop depressive symptoms. These immigrants may also see higher rates of mental health problems, which may "manifest as they attempt to integrate into educational, social or employment settings" (Venters & Gany, 2009).

1. it is hypothesized that Somali women in the United States experience a greater likelihood of depressed mood compared to national norms.

The following hypotheses aim to identify what elevated anxiety among Somali women and the different experiences between Somali women and other immigrant women in the country. According to Shekunov (2016), "refugees are at significantly higher risk for psychiatric illness compared to the general population, with increased rates of depression, somatic complaints, and up to 10 times higher rates of post-traumatic stress disorder (Shekunov, 2016).

2. It is hypothesized that Somali women in the United States experience a greater likelihood of elevated anxiety compared to national norms.

The objective of this subject is to research the significance of stress among Somali women and examine the increased stress among these women. (Hollander et al. (2011) suggested that pre-migration stressors may play a considerable role in the mental health experiences among immigrant women and non-refugee females. "The dissimilar economic, educational, and cultural backgrounds among refugees contribute to the complexity in distinguishing between consequences of pre-migration and post-migration stress (Hollander et al., 2011). It is important to note that stress and anxiety are understood to be different experiences.

3. It is hypothesized that Somali women in the United States experience a greater likelihood of heightened stress compared to national norms.

Significance of the Research

This study addresses mental health challenges among Somali women in the United States who have experienced trauma. Specifically, it focuses on Somali women's experiences of depression, stress, and anxiety as a critical and often overlooked aspect of their past and present experiences. The findings will inform stakeholders regarding the

barriers to mental health support among Somali women. The study will contribute to developing more effective and culturally appropriate suggestions for tailoring services that meet the group's specific cultural needs.

Definition of Key Terms

Anxiety: "Anxiety is an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure. People with anxiety disorders usually have recurring intrusive thoughts or concerns. They may avoid certain situations out of worry" (APA dictionary).

Depression: Depression is a mental health disorder that affects how individuals feel, the way they think, and how they act. The illness is considered to have persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities. Depression can lead to a variety of emotional and physical problems and can decrease a person's ability to function (Thornton, 2023). Posttraumatic stress disorder (PTSD) or depression is common to people fleeing from wars "compared to the general Western population as well as to non-refugee migrants" (Schick et al., 2016).

Stress: Stress is a physiological and psychological response to perceived challenges or threats, known as stressors. It can result from various factors, such as environmental changes, physical demands, social pressures, or emotional disturbances. "Stress involves changes affecting nearly every system of the body, influencing how people feel and behave" (APA, 2018).

CHAPTER II

LITERATURE REVIEW

There is no considerable research on Somali women and mental health in the United States. In Australia, a study conducted by healthcare researchers investigated the barriers to accessing mental health services in Somali-Australian women and found the influence of faith, the impact of stigma, mistrust of Australian healthcare systems, and denial of mental illness were the main obstacles to the barriers (Said et al., 2021). Another study found that Somali immigrant women in Norway have lower mental health service use than Somali men because of gender-related mental health accessibility (Næss, A., 2019).

Many European researchers have focused explicitly on Somali women and barriers to mental health in their countries. Most available articles in this literature focus on depression, anxiety, stress, cultural stigma, isolation, and service barriers (Said et al., 2021; Næss, A., 2019; Onyut et al., 2009). These studies offer valuable insights into Somali women's mental status, but limited information is available in the United States. This literature review aims to summarize the mental health barriers among Somali women in the United States and offer context as to the status of Somali women and mental health problems. The study focuses on the literature portions on depression, stress, and anxiety, which is the most significant to the study.

History of the Somali People

In the era of European colonization, multiple European countries seized Somali territories. In 1840, British East India established trade treaties of friendship and protection with different Somali elders (Metz, 1992). By 1875, Britain, France, and Italy

made regional claims on the Somali territories and started dividing the land into five regions. British Somaliland and Italian Somaliland are the lands today known as Somalia, Eastern Kenya (NFD), Eastern Ethiopia (Ogaden region), and Djibouti (Balthasar, 2017). When Somali resistance began in 1899, it became "a struggle that devastated the Somali Peninsula and resulted in the death of an estimated one-third of northern Somalia's population" (Metz, 1992, p.13). That battle has also become "one of the longest and bloodiest conflicts in the annals of sub-Saharan resistance to alien encroachment" (Metz, 1992, p. 13). The destruction of that battle also nearly destroyed the economy of the land, and many families were displaced (Reyner, 1960).

After nine years of post-colonial and two democratically elected presidents, the country's leadership went to General Siyad Bare, who grasped power in a bloodless coup in 1969 (Balthasar, 2017). In 1977, Somalia went to war with Ethiopia. According to the United Nations High Commissioner for Refugees (UNHCR), Somalia hosted 650,000 Ethiopian Somalis during that border war. Historically, Somalis were always in conflict with themselves and others. Soon after the Ethiopia war until the early 1980s, thousands of Somalis were exposed to extreme violence from the former dictatorship government in Somalia (Metz, 1993). This sequence of conflicts created decades of suffering and massive internal and external displacement, which has created many psychological and physical disasters among the Somali people. Today's ongoing conflict in Somalia has revealed the relationship between Somalia's centuries of political struggle, civil war, and mental health-related issues (Heeke et al., 2017). These traumatic events have reached Somalis living in Somalia, neighboring countries with larger Somali populations, and

Somali Diasporas who share one culture, religion, and the Somali language. (Laitin, 976; Burns, 2006).

Social Structure

Somalis are one of Africa's most culturally homogeneous societies. Their social structures are categorized as a "segmentary lineage-based political system" that traces their heritage to a common ancestor (Barnes, 2006). The fundamental norms and the characteristics of the political nature of Somali society have roots in clannism (Griffiths,1997). Most Somalis are tribal societies that usually stand together, and each family is also part of a larger subdivision of more distant cousins (Barnes, 2006). If one of the outside tribe members attacks one family of these groups, they will stand as the whole group was attacked and defend one another. For centuries, Somalis have used this tribal system politically and socially because, in Somali society, the state-run system does not exist in a clan-based society, and clan members must rely on the tribal structured system (Griffiths, 1997). Now, the country is divided into clan-based statehoods; elders choose who represents that clan at the local and federal levels (de Waal, 2020). In addition, their electoral system has long centered around a clan-based model, and this system sees elders from various clans across the country choosing members of parliament. These elected representatives select a president based on a clan-based turn-taking process (de Waal, 2020).

Mental Health

Mental health refers to one's emotional, psychological, and societal welfare, and it is a challenging illness that is also hard to recognize. It determines an individual's aptitude to work, think, feel, do day-to-day activities, or even sustain interactions with

close ones and others (Furnham & Swami, 2018). The impact of the illness can be different from one person to another; a person may have mild to moderate or severe illness. "Mental disorders are a leading cause of disability, and only a minority of people with these disorders receive treatment" (Evans-Lacko et al., 2018). The most common mental illnesses include depression, stress, and anxiety, which are influenced by different life events like conflicts, displacement, living in refugee camps, sexual violence, post-immigration issues, and many more issues or bad experiences (Neuner, 2004).

Trauma

Trauma is a hidden psychological stressful or emotional well-being caused by a traumatic event that has happened or is feared to happen, and it has different levels that are not related to the person's age, race, name, politics, or country of birth. Most of the time, it is hard to detect, but when it becomes extreme stress, it makes individuals' ability to cope very difficult. Stressful circumstances can be devastating and upsetting and place people with the sickness in a challenging position that may take too long to recover (Anassontzi & Kollia, 2022; LaCapra, 2016). Trauma is a personal experience that controls whether an event is or is not a stressful condition. In many cases, the outcomes of a traumatic experience are described based on minor emotional experiences rather than facts.

According to American Psychological Association, "Trauma is an emotional response" caused by difficult situations, including destruction by natural disasters, health-related conditions, human-made causes like conflicts, rape, difficult living conditions, and many more. Longer-term effects include erratic feelings, memories, stressed interactions, and physical symptoms (Bell et al., 2017; Kaplan, 2020; American

Psychological Association). The psychological trauma experiences and responses include the symptoms of disturbing bad memories with different stages of processing that trauma, like pre-traumatic, peri-traumatic, and posttraumatic trauma.

Today's technology and fast-based news circles that are accessible to everyone may increase Peritraumatic concerns about future happenings, whether it is natural disasters, the fear of conflicts, economic crises, or individual matters (Bell et al., 2017; Kaplan, 2020). These fears may create anxiety or stress for many people, which may affect their general health and well-being, and it may also cause major depressive illness after experiencing some of this fear distress, which may later develop into Post-traumatic stress disorder condition (PTSD). People may experience peri-traumatic events regarding climate-related events or anticipate what is to come before natural disasters happen (Garland, 2018; Bell et al., 2017). Fearing the future can also cause increased stress for many communities already experiencing climate situations or conflicts where people leave their hometowns even when it is yet to happen.

According to Kaplan (2020), "anticipatory fear for the future may well represent a traumatic condition." This fear may also increase mental health problems, leading to traumatic flash forwards after these fears end. Peri-traumatic anxiety has been significantly stated as a threat influence for PTSD for people who experience fear and distress (Kaplan, 2020; Bell et al., 2017). Vance et al. (2018) suggested that peritraumatic experiences may be valuable in forecasting PTSD signs and other mental illness indicators and the severity of a person's PTSD-related symptoms after exposure. "There is evidence that peritraumatic distress is one of the most powerful predictors of PTSD symptoms" (Megalakaki et al., 2021).

In Somalia alone, according to Ibrahim et al. (2022), climate-related distress, mainly drought and flooding, displaces millions of people each year, which causes extensive psychosocial traumas. Being displaced can create substantial trauma, and this uncertainty about what happens next can cause depression and anxiety among individuals, which may raise the possibility of increasing mental health conditions.

Depression

Depression is a cognitive illness commonly identified by an insistent sense of grief and hopelessness to experience desire that shakes individuals from mild, moderate, and severe illness. Which sometimes severely restricts psychosocial functioning and weakens the quality of life. (Malhi, et al., 2018). Sometimes, it is not only a brief emotion of sorrow but a deep and lasting misery and suffering for the individuals it affects. Dream experiment examining depressed and non-depressed individuals shows that “the depressed patients showed a significantly higher number of dreams with "masochistic" content than the non-depressed patients” (Beck & Hurvich,1959).

Depression illness can be short-term or long-term and may interfere with one's relationship with loved ones and everyone around them or their daily life functioning. According to McCarron et al. (2021), "depression is a leading cause of disability and years of productive life lost, and only about half of depressed persons receive adequate treatment despite the existence of high-quality, evidence-based therapies." People who have lived through conflicts, severe losses, displacement, abuse, or other stressful events are more likely to develop depression. It is also the leading risk factor for suicide, and suicide rates in the United States have increased by roughly 35% since 1999 (Centers for Disease Control and Prevention, 2020).

Many people running from conflicts may also experience posttraumatic stress disorder symptom clusters: intrusions, avoidance, arousal, active avoidance, passive avoidance, anxiety symptoms, and depression symptoms (Onyut et al., 2009, p. 6). Thousands of these individuals seek refuge in Western countries like the United States each year. Data collected between 2010 and 2020 show that 64 percent of all refugees admitted to the United States were women and children under the age of 14 years because of their vulnerability to conflict traumas (Monin et al., 2021). When refugees are resettling to new countries, they do not know they may lose social support and community connection (Rashoka et al., 2022).

Furthermore, cultural stress related to language difficulties and Western cultural adaptation increases refugee trauma after migration. Many Somali immigrants prefer to resettle in towns or states with larger Somali communities. They would be more likely to turn to one another for support, and such support would serve a protective role in psychological outcomes (Veronis & McLeman, (2014). On the other hand, the ongoing conflict in Somalia has revealed the relationship between the war and mental health-related issues among the Somalis (Heeke et al., 2017). Because of the displacement from their homeland, many Somalis with mental health illnesses have felt lonely, helpless, and isolated by fear of stigma and name-calling related to their conditions (Jorgenson et al., 2021). Many Somalis who are depressed or have other mental illnesses prefer to remain hidden from their families and societies and might not seek professional services (Heeke et al., 2017).

The violence these refugees witnessed during the war and the harsh living conditions in the refugee camps have increased the trauma they already experienced.

Heeke et al. (2017) study found that individuals who witnessed conflicts are at risk for "prolonged grief disorder and posttraumatic stress disorder symptoms following" the death of their loved ones or witnessed horrifying and threatening experiences. Many Somalis have had the opportunity to seek refuge in Western countries since the war in Somalia started, and the number of refugees living in Western countries is on the rise because of the continued resettlements of these refugees (Pew Research Center, 2016). Although Somalis started to migrate in the 1960s as students and professionals in the United States, the number of refugees arriving has risen dramatically following the civil war in the 1990s. The relocation of Somalis in the United States has become one of the largest refugee resettlements in North America and represents about 7% of the world's Somali migrant population refugees (Pew Research Center, 2016).

According to the Centers for Disease Control and Prevention (2021), "more than 47,000 Somali refugees arrived in the United States From 2010 to 2016 fiscal years, October 1 to September 30" (Centers for Disease Control and Prevention, 2021). These new refugees are resettled in different states as other refugees come before them, and "the loss of social support, homes, financial, and occupation status can cause many refugees to suffer further traumatic effects such as depression, chronic stress, and severe isolation and loneliness" (Rashoka et al., 2022). These losses are often experienced by women and elderly refugees, who must cope with severely reduced social networks and community ties.

According to the Pew Research Center (2016), approximately two-thirds of all Somalis living outside Somalia live in its neighboring countries, namely Kenya, Ethiopia, Djibouti, and Yemen. A study conducted in the Melkadida refugee camp in Southeast

Ethiopia found that more than one-third of surveyed refugees reported symptoms consistent with depression (Feyera et al., 2015). Women were twice as likely to show signs of depression, "depressive symptomatology was related with female gender, being divorced; forcefully displaced as refugee previously; witnessing the murder of the family or friend and experiencing lack of house or shelter" (Feyera et al., 2015, p. 2). In addition, many who survived the war and the hardship of life in the refugee camps now experience language, culture, economic, and educational barriers in Western countries.

Anxiety

Anxiety is defined as a mood of concern, nervousness, or a tenacious feeling of sorrow, which can be visible both emotionally and bodily. It is a common measure that can be part of our lives, but it may also interfere with individuals' daily performances physically and mentally. According to Michelle et al. (2009), the signs of anxiety incorporate fear or feelings of looming danger, avoidance, muscle tension, difficulty concentrating, and other physical symptoms and mental concerns. Anxiety disorders are categorized by a conscious awareness of the tendency to focus on some aspects while ignoring others regarding threats that can trigger a physical or behavioral change or threat-related attention bias. When anxiety occurs, it may cause partial processing of emotionally loaded personal meaning, which can distress the person's conscious awareness (Cartwright-Hatton et al., 2014; Craske et al., 2009).

Anxiety is a complex illness, and different issues can contribute to individual anxiety conditions. However, anyone can experience anxiety, which can be triggered by a combination of factors, including "underlying psychological causes, early life experiences, relationships, exposure to stressful and negative life or environmental events

and emotional expression" (Szuhany & Simon, 2022). People can also experience feelings of intense anxiety like fear or frightening situations that may hardly impact their quality of life for an extended period. Individual emotion can be one of the factors leading to anxiety disorder because when an individual experiences a distressing incident, such as emotional or physical mistreatment, economic hardship, displacement, or death of a loved one, and many other issues that can contribute to or aggravate anxiety disorder. Because "emotion regulation appears to be a distinct construct that may causally influence fear/anxiety expression" (Cisler et al., 2010).

Undergoing early-life trauma can considerably influence anxiety symptoms in future life because when individuals experience antagonistic incidents, it may impact their exposure to anxiety. According to Syed & Nemeroff (2017), "early life stress has demonstrated clear association with many psychiatric disorders including major depression, posttraumatic stress disorder, and bipolar disorder." Each year, millions of people experience forced displacement, loss of loved ones, homes, and access to basic needs like education and healthcare. These individuals who may grow up or have lived in this environment regularly face inimitable challenges "ranging from mild stress reactions to problems such as anxiety, depression, substance abuse, and posttraumatic stress disorders (PTSD)" (Prasad & Prasad, 2009). It may not even be easy for them to get mental health support to help them recover from these emotional wounds. It may also affect their emotional health, social skills, and capability to trust even the closest one.

According to Zeidner et al. (1994), during wartime, people experience trauma in different ways, which may contribute to the escalation of a mixture of trauma signs like anxiety. Also, personal traits might be disposed to anxiety in the conflict areas because

individuals with neuroticism and an inner-oriented disposition are more likely to feel anxious. "Furthermore, anxious individuals would be expected to process traumatic emotions less satisfactorily than less anxious individuals." (Zeidner et al., 1994). In addition, past experiences can shape how individuals cope with and respond to stressors. On the other hand, the level of anxiety among women during conflicts and displacement differs depending on different factors, such as the specific circumstances of the conflict, individual resilience, and available support systems. However, it is well-documented that women often face unique challenges, and women can be heightened vulnerabilities during times of conflict and displacement.

Murthy & Lakshminarayana's (2006) research about mental health consequences of war found that "women had a poorer mental health status, and there was a significant relationship between the mental health status and traumatic events among women" The study found that during and after wars women might have higher rates of anxiety than men and their symptoms may be related to higher numbers of painful experiences, they might encounter including displacement, losing loved ones, homelessness, and losing their social lives (Barakovic et al., 2013). In addition, women have a bigger chance of physical and sexual violence during and after conflict events. This distress for their well-being and the security of their families could contribute to a high level of anxiety. In addition to these problems, women also face challenges in accessing essential resources like healthcare, and many displaced women have anxiety when lucking essential services, which may contribute to further stress and anxiety (Floyd & Sakellariou, 2017).

Stress

Stress is a psychological pressure or the normal reaction to everyday pressures instigated by a challenging reaction supported by bad feelings or fear that, at some point, every human experiences in their lifetime. Individual reactions and the causes of stress have completely different responses and outcomes (American Psychological Association; Neuner et al., 2004). Stress can come during our routine day-to-day living, fear of something, financial issues, remembering something bad that happened, or being afraid to happen again. Refugees who have fled from conflicts regularly described their experiences of tremendous stress that impacts them physically and psychologically (Neuner et al., 2004). Many people escaping conflicts seeking sanctuary in refugee camps or far away countries can still experience stressful lives during their living in these areas.

In addition, experiencing past violence, poverty, dependence on humanitarian aid, and suffering from malnourishment can also increase stress (Neuner et al., 2004). Stress plays a critical role in the mental health of people who fled conflicts and resided in camps, adding to their stress, while traumas always impact these refugees living in the camps and can leave them with a long-lasting impact (Neuner et al., 2004). Many studies have shown that experiencing conflicts and displacement can play a significant role in suffering stressful conditions. In contrast, many war refugees exposed long-lasting distress after many years away from the conflicts and complex conditions in refugee camps.

For many Somalis, stress was not new to them. The military rule that took over the civilian government in 1969, the Somalia-Ethiopia war in 1977, and the Northern clan war fares against the government created decades of suffering and massive internal and

external displacement. In early 1991, when the war reached the capital city of Mogadishu and central and southern regions, millions more people fled to neighboring countries while others became internally displaced inside Somalia. These decades of conflict trauma, lack of health care, food shortage, security issues, and unemployment have become the most significant challenges in Somalia and the refugee camps (Jorgenson et al., 2021).

Moreover, the stress women experience as they escape conflicts goes beyond the one the whole refugee communities face daily. Criminals and sometimes the security personnel in the camps or entry areas took advantage of women by committing gender-based acts of violence (Crisp, 2000). These traumatic incidents and stressors related to incidents in refugees' countries of origin and the lived conditions within the refugee camps often contribute to an accumulation of distress (Jorgenson et al., 2021; Heeke et al., 2017; Neuner, 2004).

Even after the resettlement of the immigrants from refugee camps to Western nations, the acculturation stress becomes particularly noticeable for individuals belonging to minority racial or ethnic groups. The process of adapting to a new cultural environment is challenging. When combined with reasons such as discrimination, marginalization, and cultural bias, it significantly heightens the negative impression on the psychological health of immigrants from minority backgrounds. According to Greenwood et al. (2017, p.1), "Immigrant women who belong to the same majority racial or ethnic group as the host culture would report experiencing more ordinary privileges than immigrant women who do not." On the other hand, minority women may face increased levels of discrimination and prejudice in their host countries. Such experiences

contribute to a sense of alienation, eroding the individual's self-esteem and creating a hostile environment that exacerbates acculturation stress. Many refugees resettled in many Western countries may confront challenges related to social exclusion, unemployment, discrimination, and racism. These resettlement stressors, acculturative stressors, and perceived discrimination were all linked with post-traumatic stress disorder symptoms (Betancourt et al., 2015).

Cultural Stigma and Western Treatment

In the Somali communities, stigma is the number one obstacle preventing mentally ill individuals from seeking professional support because of the negative pictures related to the name of the illness. In Somalia, most people with mental illness seek and get mental health care services from religious or traditional healers at first (Bettmann et al., 2015). Many of these individuals believe that only people who are crazy seek mental health professional treatments. They believe stress and depression are healable through Quran reading or other traditional ways, but their disease is spirit possession, witchcraft, or evil eye (Ibrahim et al., 2022). Even those who know there is a treatment keep their mouth shut for fear of stigmatization within their family members or communities. That is why "Somali refugees' risk not accessing proper mental health services due to their cultural beliefs and stigma around mental health concerns" (Bettmann et al., 2015). People fleeing war zones increase many risks for mental health issues, which might signal irregular actions that worsen their ability to manage social and family life (Lacour et al., 2020). In addition, Somalis who survived the war and the hardship of life in the refugee camps and relocated to Western countries have experienced language, culture, social, economic, and educational barriers.

In many countries, including in the United States, government-sponsored refugees had little option in selecting the State or town of their choice of destination. Most Somalis who were submitted as refugees get their permanent residence as refugees and are eligible for naturalization in five years. However, getting permanent residents or community connections might not help most individuals with mental health-related issues that many face after resettling to their new country because of barriers to access to quality healthcare services.

Although Minnesota has the largest Somali population in the United States, "Somali refugees in Minnesota are among the least served by Minnesota's health and social service systems" (Pavlish et al., 2010). There are immigrant health inequalities in the United States and the country, which is why these immigrants have negative or positive beliefs about Western medicine. However, those from urban areas in their original countries have experience with Western medicine, although they have different opinions about what it treats and does not treat (CDC, 2021).

Many Somali refugees were unaccustomed to mental health services like psychotherapy treatments because "the Western cultural notion of mental illness substantially different from what applies to their culture" (Majumder, 2019). Some of them believe only medication prescribed by medical doctors treats mentally ill people and do not accept psychotherapy treatments even when performed by a licensed mental health professional. When Somalis visit a medical doctor, they will not separate physical symptoms from emotional symptoms because it is understood as a whole and undivided to report physical pain even when experiencing mental illness (Bhui et al.,2003).

During doctor's visits, Somali women may report the physical pain they are experiencing, like headaches, joint pain, or other pains in the body, and mix up mental illness symptoms with other illnesses, which is common for many communities that have experienced conflict-related traumas. Many of these refugees cannot explain and differentiate their mental health symptoms from other health-related illnesses. According to Danner et al. (2007), a "number of Hmong women who talk to their primary care physician about their illness presented "somatic complaints which were difficult to categorize in terms of Westernized medicine as well as symptoms of depression" (Danner et al., 2007). Many refugee women might feel dissatisfied with their healthcare providers because they were not treating the pain they were experiencing and wasting their time by just talking and not prescribing medicine for their illnesses (Pavlish et al., 2010).

Many perceive mental health therapy as a waste of time. If they want to talk about their private emotional symptoms, they seek trusted cultural healers or religious people who they believe keep their mental illness secret. This trust issue was primarily similar to those who did not speak English and needed translators during treatments but were still struggling with mental health stigma. Many refugees cannot find commonality with others, including professionals helping them, so many still have difficulty trusting mental health specialists (Guerin et al., 2006).

Traditional and Religious Practices

More than half of the Somali population in East African regions live in rural areas where modern medicine is inaccessible because of the nomadic living conditions, and families regularly move to wet or grassland areas (O'Neill, 2023). Because of these conditions, social rejection, shame, embarrassment, and discrimination might inspire

mentally ill individuals to reach only trusted traditional healers instead of professional services (Johnsdotter et al., 2011). In Somali culture, traditional healers are perceived as more trustworthy and sympathetic to people with mental health illnesses.

Rural and urban communities have concepts of the roots and therapeutic of illnesses like other communities that depend on this traditional medicine. Somali nomads depend on traditional treatments like herbal, plant, and cautery therapy, which is common in some urban populations (Michlig et al., 2022). Although Western medicine did not thoroughly study these traditional treatments, Somalis used them for centuries to cure different diseases. Many people prefer this traditional method because of their trust and the satisfaction they gain from it (Tesfai et al., 2020). Most Somalis believe depression and stress can be treated only by medicine that makes patients calm and relaxed or by Quran reading but not therapy.

The Somali traditional healers do not provide treatment for mental health-related diseases or recognize them as illnesses. However, a particular traditional healer treats patients who believe spirits or evil eyes possess them. Usually, family and friends of the patients come together to eat food, sacrifice animals, and play drums with traditional dances and singing. Most mentally ill patients in Somalia were held at home, confined, and secured by a chain to safeguard them from potential acts of violence and improper actions, or sometimes people harassing the mentally sick person (Bettmann et al., 2015).

The families of the mentally ill person are typically responsible for the healing procedure, while the ill person's opinion is mainly ignored. In addition, during and after treatment, most families play a critical role by providing physical, psychological, and spiritual care for the ill person and facilitating all dealings with the healers. Somali

societies characterize traditional healers as intercessors and their spiritual world, self-assure, and influence to encourage sick people to have adequate tolerance to understand their obstacles (Ahmed & Puglielli, 1988).

In addition, in Somali society, Islamic values and cultural healing are fundamental to Somali identities and culture (Padela et al., 2012). Most Somalis believe the Holy Quran offers a divine direction to treat any disease, and Quranic readings and prayers are crucial for dealing with mental health illnesses (Zoellner et al., 2021). Psychotherapy and drug treatments were not new to the Eastern culture; according to Sabry & Vohra (2013), one of the most outstanding Islamic physicians, Dr. Al Razi, was the first to invent psychotherapy and drug treatments and the founder of the first psychiatric hospital ward in the world during the late 8th and early 9th century. He also introduced the theory of an association between the body and mind and the need for medical treatment. He also considered mental illnesses as medical conditions that need to be treated with psychotherapy and drug treatments (Razak, 2017).

Today, many Muslims follow in his footsteps of "respect, care, and empathy" for mentally ill individuals, which is also part of the Islamic theory of treating fellow humans (Sabry & Vohra (2013). However, the older Somali generation and women mostly tied their health issues to Islamic devotion using different healing practices. Mostly, they pray for more and more hours to read the Quran to themselves or for Sheikhs (Clerics) to recite it (Pavlish et al., 2010). They mostly feel very comfortable talking to religious leaders about their depression and stress but do not feel comfortable telling healthcare professionals about these illnesses. Somalis practice and always consider Islamic healing their first option and refer any health issues to that healing because it tackles social

relatedness and perceived arrangement with their religion, which is enormously significant to their acceptability and commitment to mental health interventions (Bentley et al., 2021). They believe that if you devote and refer your health issues to God, you get better results in your mental functioning (Sabry et al., 2013). "Whoever puts their trust in Allah, then He ˹alone˺ sufficient for them. Certainly, Allah achieves His Will. Allah has already set a destiny for everything" (Quran, 65:3)

Furthermore, Islam is essential in managing negative social experiences that might psychologically impact individuals' well-being. Social connectedness and community building are targeted in Islamic trauma healing (Sabry et al., 2013; Pavlish et al., 2010). The religious leader and the family of the mentally ill person create social interaction and trust and then share discussions about "prophets' narratives that explore themes of trauma exposure and common reactions to trauma." (Bentley et al., 2021). Therefore, Islamic counseling is one of the strategies that help with prevention and treatment. However, a large portion of the Somali community considers mental illnesses as medical conditions that need to be treated with psychotherapy and drug treatments (Razak, 2017). The first role of the Muslim cleric for the sick is to "provide advice which would be following the Quranic principles and teachings of the Prophet Muhammad" (Sabry & Vohra, 2013, p.207).

The second most practiced Islamic therapeutic is performing Quran recitation by clerics who use several rituals to treat patients. Muslims believe that the Quran offers a foundation of divine direction to treat, and it has the power to heal any sickness. Therefore, Quranic readings and prayers are crucial for dealing with mental health

illnesses (Johnsdotter et al., 2011). The faithful individual's Quranic readings and prayers are crucial for dealing with mental health illnesses.

Barriers to Services for Somali Women

Immigrants' identities intersect in complex ways, and these junctions significantly impact their experiences and vulnerabilities, especially women who often find themselves navigating a complex web of challenges heightened by traditional gender roles, societal expectations, stigmatization, expectations to fulfill specific societal norms, and limited access to reproductive health services. This experience could be profoundly marked by vulnerability as these women grapple with multifaceted pressures that shape their daily lives. According to Freedman (2016), many immigrant women who experienced gender-based violence while in Western countries might not report it because of "stigma, shame, and fear of reprisals among other barriers and additional barriers such as not knowing the language, not knowing who to report to and other fears." In many cultures, traditional gender roles persist, assigning specific responsibilities and expectations based on gender. Therefore, many immigrant women might resist or face difficulties breaking free from these roles, limiting their agency and perpetuating vulnerability. For instance, the expectation to adhere to traditional caregiving roles could constrain opportunities for education or employment (Næss, 2019).

A lack of understanding of Somali clients' personal, religious, and cultural perspectives toward their mental health beliefs prevents many from getting effective treatments for their illnesses ((Ibrahim et al., 2022; Linney et al., 2020). Identifying individuals with emotional distress in the Somali community could be challenging because of the difficulties in accessing Western treatments. Many Somali individuals

with trauma or emotional distress are more likely to hide their emotions and feelings because of the stigma associated with the illness. Some other Somali individuals' options to get treatments could be through support from traditional and religious institutions that could not heal their illnesses. However, some individuals are willing to try this healing strategy to make them feel better about their depression problems (Said et al., 2021; Michlig et al., 2022). Cultural stigmatization is a common distress for Somalis who do not access mental health care services. Most Somalis cannot describe their emotional experiences like depression, anxiety, or stress to professionals even if they suffer very badly (Linney et al., 2020; Næss, 2019).

These obstacles increase the barriers that have already created mental health services disparities. The lack of culturally sensitive care is another barrier: "Somali communities globally have relatively high levels of mental illness, but low levels of mental health service use, with numerous barriers" (Linney et al., 2020). Somalis may feel that Western medicine providers do not respect or understand their needs. At the same time, healthcare professionals have not been alerted to these issues because "the Western biomedical approach to health care tends to be new to Somalis who also find the Western healthcare system overwhelming and difficult to comprehend and navigate" (Lazar et al. 2013).

In addition, some professionals are unwilling to learn about these immigrants' backgrounds, cultures, and belief systems rather than make assumptions about them. (Degni et al., 2012; Lazar et al., 2013). Lack of cultural training for healthcare providers can make them unattractive to many immigrant patients. "Communication difficulties due to language and cultural differences between health care professionals and patients are

widely recognized as a major barrier in providing health care services" (Degni et al., 2012). These conditions do not allow for more individualized care, reflecting any possible cultural differences between Somali patients and medical providers. Furthermore, a lack of effective dialogue and trust can create a massive gap between patients and professionals.

In the United States, most immigrant "women are more proactive to seek professional mental health care services due to their favorable opinions of professional help-seeking" (Mohammadifirouze et al., 2023). However, the fear of stigmatization could make it hard for Somali women to consider talking about their emotional stress illnesses even if they have them. Some of them may fear losing their livelihood, becoming isolated from the community, being taken away from their kids, or being taken to a mental health hospital (Shannon et al., 2015). How mentally ill individuals could be treated or perceived in the Somali community can cause stigmatization and may prevent many women with emotional stress from seeking professional help (Ahmed & Puglielli, 1988; Wei et al., 2015). Also, the barriers between men and women regarding treatment and accepting mental illness have affected women's options for treatment. In Minnesota, there are mental health group homes for men, and it is rare to see female group homes because women must not let people know about their sickness (Shannon, 2014). Although separation is most common among Somali immigrants in Denmark, a tiny number of women use outpatient mental health services because of their gender stigma (Nielsen et al., 2015)

In addition, cultural norms about gender influence whether individuals seek help for mental health issues because individuals of different genders may react differently to

mental illness difficulties. For many women, being a female may increase the odds of depression and anxiety symptoms, and the social stigma of being a female in the Somali community leads to under-reported female mental health signs (Rask et al., 2016; Nielsen et al., 2015). In the Somali culture, there is a conservation of traditional gender principles that form obstacles and chances for mental health utilization (Næss,2019; Onyut et al., 2009). There are elevated "posttraumatic stress disorder and depression" and connections between mental health illnesses and conflict experiences. The conflict trauma continuously impacts refugees' mental health even after moving away from the war zone (Onyut et al., 2009).

During conflict and post-migration, women experience significant stress that can impact their emotional status. Migration-related factors also influence many social and health difficulties among migrant women, and barriers to care are likely to occur (Straiton et al., 2022). For these reasons, it is complicated to measure the correct number of Somali women with stress, depression, or anxiety because the lower use of psychologists compared with other ethnic women and earlier life experiences of immigrants can be the factors behind treatment refusal. Experiencing conflicts and migration can reinforce the perception existing in society about women and mental health (Byrskog et al., 2014). Problems with professional recommendations and lacking cultural skills and information of healthcare providers worsen agreeable treatment with some Somali patients.

Isolation from Other Women

For many Somali women, the isolated environment they encounter in their adopted new countries makes them more likely to develop depression and anxiety than women who have not experienced displacement or wars. Some Somali refugee women

believe that mental "illness had stronger roots in explanations such as spiritual dissonance, social disconnection, and sadness" (Pavlish et al., 2010, p. 355). Somali women also experienced depression and anxiety in the hosting nations because of a lack of social integration and resettling to countries with different cultures and norms. Because their social relationship bonds with other Somali women have vanished, and women become more isolated than ever (Guerin et al., 2006). Therefore, Somali women may avoid social interaction due to profound anxiety and depression (Næss,2019; Onyut et al., 2009).

The physical and collective circumstances of the settlement of Somalis in a new environment can make it very difficult to build the same social relationships they have in their homeland (McMichael & Manderson, 2004). Most immigrants often lose some characteristics of their social integration, and it becomes hard to form the same social networks they used to have or develop a sense of belonging because of the Western social routines, economics, language, and other barriers (Barker, 2021). In addition, mental disease repudiation, gender obligation, and safeguarding social values and family reputations might raise the opportunities not to seek and accept mental-health services for Somali women (Ibrahim et al., 2022).

Awareness and Access

Hartwig et al. (2016), when adapting to a new country's social environment, immigrants face new challenges and struggle to manage past traumas. Healing and treating refugees' traumatic experiences must improve their social, physical, and emotional health by creating activities and services to help refugees cope with their new environment, which many of them do not get (Hartwig et al., 2016). Creating therapeutic

activities like gardening and other hobbies that refugees used to do in their homeland reduces their mental and emotional troubles, and this community-based social support transforms refugees' integration and mental and physical health (Hartwig et al., 2016).

Community involvement experiences of individuals with mental illness and their families can support individuals struggling with mental health, and this involvement recognizes their feelings towards the illnesses. It can define or remove behavioral barriers like stigma and discrimination. (Hall et al., 2019). Community inclusion is critical in decreasing stigmatization and changing negative views about mental health illnesses (Hall et al., 2019). There is much cohesion between mental health beliefs and the stigmatization of individuals with mental illness. Inadequate mental health knowledge, lack of proper interaction with the community, and the accessibility of mental health care services prevent individuals from seeking help and increase negative views towards mental illness stigma (Wei et al., 2015).

Mental health literacy can develop a receptiveness strategy to decrease stigma and change negative behaviors toward mental illness. It can also be essential to develop an understanding of health issues awareness in many communities because when people know about their condition, they will identify when an illness is emerging, know help-seeking choices and care that are accessible, and support others impacted by the illness (Jorm, 2012). Healthcare awareness can also empower stakeholders to get mental health treatments, and it is the aptitude to increase accessibility and influence people to understand and construct successful habits of healing knowledge to comprehend and follow treatments (Jorm, 2012).

Summary

More research is needed to promote understanding and address mental health barriers Somali women face when experiencing trauma because there is inadequate research about Somali women's mental health in the United States. It is essential to be able to research areas of stigma and barriers because the review of the literature offered a limited understanding of the experiences of depression, stress, and anxiety among Somali women in Western nations. Individuals affected by conflicts always experience psychological and emotional suffering even after they move to a safer and more stable environment, and women are more susceptible to illness because of the extra responsibilities (Naess, 2019). Each year, millions of people experience trauma events like depression, stress, and anxiety in different ways, but for many, perception, stigma, and gender may prevent them from seeking treatments. Depression, stress, and anxiety are particularly common among Somali women due to a combination of traumatic experiences, cultural challenges, and socioeconomic factors.

Somali women have lived through the civil war in Somalia, witnessing and experiencing violence, loss of loved ones, and destruction of their homes. The journey to safety often involves perilous travel, time in refugee camps, and separation from family members, all of which are traumatic. Adapting to a new culture in the United States can be challenging because social isolation, language barriers, different social norms, and cultural practices may contribute to stress and anxiety. In addition, fulfilling traditional roles and balancing traditional Somali values with the expectations of life in the United States, economic hardships, including unemployment and low-income jobs, can create

depression and stress. At the same time, a lack of healthcare accessibility can also increase these traumatic illnesses

CHAPTER III

METHOD

Participants

Fear of stigma and a history of trauma prevent many Somali women from participating in mental health-related studies or even talking to professionals about their illness because of the related cultural history of mental health name-calling related to their conditions. Therefore, this study recruits Somali women in the Minneapolis-Saint Paul Metropolitan area through mental health clinics, community centers, and schools. It was anticipated that these subjects would be Somali women who experienced the effects of trauma and first-generation Somali women who were born or grew up in the United States and have not directly experienced trauma from conflicts.

Measures

The participants were asked to respond to scales measuring three factors: (a) depression, (b) stress, and (c) anxiety. Depression was evaluated via the *Beck Depression Inventory-II (BDI-II*, Beck, Steer, & Brown, 1996). The *BDI-II* Beck is a twenty-one self-report item with four response options on a scale of 0 to 3. Mouanoutoua et al. (1991) study on Hmong refugee demographic study showed a high coefficient alpha (.93), test-retest reliability (.92), and a significant mean score difference between the non-depressed group (M = 39.11, SD = 7.76) and the depressed group (M = 55.46, SD = 5.50).

Stress was measured by the *Refugee Post-Migration Stress Scale* (*RPMS*, Malm et al., 2020), a 22-item instrument of post-migration stressors that include perceived discrimination, lack of host country-specific competencies, material economic strain, loss of home country, family and home country concerns, social strain, and family conflicts

(Malm et al., p. 8, 2020). Malm et al. (2020) found that the internal consistency of the seven factors of *RPMS* ranged from 0.74 to 0.87

The *Generalized Anxiety Disorder Assessment-7* scale (*GAD-7*; Spitzer, Kroenke, Williams, & Löwe, 2006) was used to measure anxiety symptoms. This seven-item measure has demonstrated good consistency and validity (Spitzer et al., 2006). Each item of the GAD-7 asks the subject to rate the condition of his or her symptoms. It reveals anxiety symptoms as mild, moderate, and intense. Bjärtå et al. (2018) found the *GAD-7* highly reliable (Cronbach's $\alpha = 0.92$; intraclass correlation = 0.83). In addition, population tally descriptions were collected to improve the study's data gathering regarding age, gender, and race. Finally, a demographic record helps understand the subjects' history of mental health conditions and how their experiences may differ from one subject to another.

Design

This quantitative study tested Somali women from different backgrounds and experiences of conflict. We recruited subjects by contacting schools and community centers in the Twin Cities metropolitan area by phone and email to inform them about the study's purpose and the target subjects. The study has passed fliers that were bilingual Somali/English, with the purpose of the study and eligibility requirements (age, gender, and general information about the study). Recruitment occurred both in English and Somali, explaining the need for volunteers to participate in a survey regarding Somali women who live in the United States and may experience depression, stress, or anxiety.

Once recruited, participants were given an informed consent form with all the appropriate information about the research to ensure they could decide whether to

participate willingly or not. The informed consent form was written in English and Somali, so those who cannot read one of the languages can use the preferred one. The informed consent summarized the purpose of the study, the researcher's contact information, benefits, and risks, if any. The informed consent forms were available online, in hard copy, and by email. QR codes were generated when creating the survey in Qualtrics, and the online survey has a link to that QR code, which was sent to the subjects who took a picture with their cell phone to take the survey automatically.

Procedure for Data Analysis

Data was analyzed using Jeffreys's Amazing Statistics Program (JASP; https://jasp-stats.org). Specifically, descriptive statistics were conducted and reported to analyze the frequency of responses and measures of central tendency, variability, and relationships between the variables of depression, stress, and anxiety among Somali women in the United States. In addition, an intercorrelation matrix was used to identify potentially meaningful relationships among these factors.

CHAPTER IV

RESULTS

Depression, stress, and anxiety are widespread worldwide and affect individuals from all walks of life (Shawyer et al., 2014). In communities with a history of conflict, displacement, and economic difficulties, the impact of these conditions is often intensified (Heeke et al., 2017). Somali women's historical and cultural contexts play a significant role in shaping their well-being, and it is crucial to understand the challenges these women face to develop effective support systems (Næss, 2019). We investigated the connection between depression, anxiety, and stress among Somali women living in the Metropolitan area of the Upper Midwest United States. The unique social norms and expectations of traditional Somali culture can both alleviate and exacerbate mental health issues. For example, a strong sense of community and support from extended family members can help alleviate stress and anxiety.

The cultural stigma surrounding mental health issues can make it more difficult for individuals to seek the help they need. Somali women have often faced such complex stressors related to displacement, cultural adjustments, and economic hardship, making them a unique group to study in terms of the impact of depression, stress, and anxiety (Ahmed & Puglielli, 1988). Through a quantitative analysis, this study attempted to elucidate how varying levels of depression, stress, and anxiety correlate with those psychological outcomes in this population.

First, it was hypothesized that Somali women in the United States experience a greater likelihood of depressed mood compared to national norms. Second, it was hypothesized that Somali women experience a greater likelihood of elevated anxiety

compared to national norms. Third, it was hypothesized that Somali women experience a greater likelihood of heightened stress compared to national norms. These hypotheses underscore the need for a nuanced understanding of the mental health challenges faced by Somali women, acknowledging the unique cultural and historical contexts that shape their experiences.

Demographic Characteristics

The typical subject in this study (n = 53) was a Somali woman living in a major Metropolitan area in the Upper Midwest with a mean age of 35.64 (SD = 10.37). The sample of Somali women ranged from 18 to 69 years old. Subjects were recruited through several venues, including parent-school meetings in an elementary school, early childhood classes, and community centers.

Scoring Table

Scoring the Beck Depression Inventory (BDI-II)

Classification	Total Score	Level of Depression
Low	1-10	Normal ups and downs
	11-16	Mild mood disturbance
Moderate	17-20	Borderline clinical depression
	21-30	Moderate depression
Significant	31-40	Severe depression
	Over 40	Extreme depression

Scoring the Refugee Post-Migration Stress Scale (RPMS).

Classification	Total Score	Level of stress
Low	1-2	Low to moderate
Moderate	3	Moderate Concern
Significant	4-5	Severe stress

Scoring the Generalized Anxiety Disorder Assessment-7 (GAD-7

Classification	Total Score	Level of anxiety
Low	0-4	Mild
Moderate	5-9	Moderate
Significant	10-14	Moderate severe
	15-21	Severe

Psychological Status

A set of validated scales was utilized to understand better the experience of Somali women who had emigrated or were born in the United States, specifically in a major metropolitan area of the Upper Midwest, regarding depression, anxiety, and stress.

Depression

In order to measure depressed mood, subjects were asked to respond to the *Beck Depression Inventory-II (BDI-II;* Beck, 1996). Depression was a common experience among the Somali women. Indeed, on average, they reported experiencing "severe depression" per the scale norms (M = 34.57, SD = 16.32). This result confirmed the first hypothesis that suggests that depressed mood was experienced among Somali women in the study sample.

An item-level consideration of responses to the *BDI-II* can potentially shed light on the subjects' experience. Responses to the *sadness* item revealed a mean value of 1.40 (SD = 0.84). This indicates a relatively low level of sadness with only moderate variance among the subjects. Responses to the *pessimism* item revealed a mean value of 1.50 (SD = 1.25). This indicates a moderate level of pessimism, with only moderate variance among subjects. Responses to the *past failure* item revealed a mean level of 1.20 (SD = 1.00). It indicated a mild level of past failure, with some response variability. Overall, these results provide insight into the extent to which feelings of past failure are experienced among the assessed population. Respondents reported mild feelings of past failure with some consistency across responses in this finding.

Responses to the *loss of pleasure* item revealed a mean value of 1.83 (SD = 1.74) This indicates a relatively low level of loss of pleasure with moderate anhedonia among

the subjects. Responses to the *guilty feelings* item revealed a mean value of 1.10 (*SD* = 1.09). This indicates mild to moderate levels of guilt feeling. Responses to the *feelings of punishment* item revealed a mean value of 1.17 (*SD* = 1.03). This indicates moderate feelings of punishment with only considerable variance among subjects.

Responses to the *self-dislike* item revealed a mean value of 1.08 (*SD* = 0.92). This indicates a mild level of self-dislike. Responses to the *self-criticism* item revealed a mean score of 1.42 (*SD* = 1.51). This indicates a relatively low level of self-criticism. However, this variability implies that while some individuals may experience deficient levels of self-criticism, others may experience much higher levels, reflecting a broad range of self-critical tendencies within the population (*BDI-II*; Beck, 1996).

In the context of the *BDI-II* (Beck, 1996), responses to *suicidal thoughts* item revealed a mean score of 0.91(*SD* = 0.88). This indicates a relatively low level of low levels of suicidal thoughts. A mean score slightly below 1 suggests that, while some participants may have occasional or mild suicidal thoughts, these thoughts are generally infrequent or not severe for the majority (*BDI-II;* Beck, 1996). Responses to the *crying* item revealed a mean value of 1.55 (*SD* = 1.07). This indicates that, on average, respondents reported experiencing crying episodes at a moderate severity level. This variability implies that while some individuals may experience minimal crying, others may report more frequent or severe crying episodes (*BDI-II;* Beck, 1996). These results highlight that crying was a notable symptom within this group, potentially reflecting the overall emotional distress and depressive symptoms experienced by the respondents.

Responses to the *agitation* item revealed a mean value of 1.66 (*SD* = 1.44). This indicates the average level of agitation reported by the individuals in the sample.

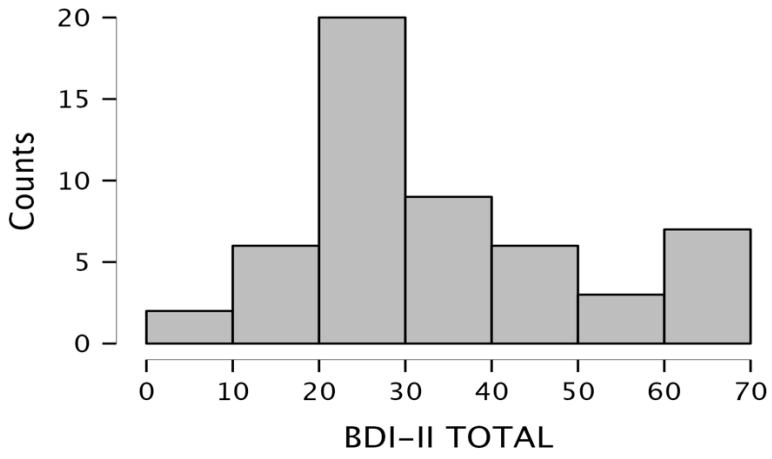
Responses to the *loss of interest* item revealed a mean value of 2.15 (*SD* = 1.77). This indicates a severe level of loss of interest experienced within this group. Responses to the *indecisiveness* item revealed a mean value of 1.83 (*SD* = 1.31). This indicates that, on average, subjects reported experiencing moderate indecisiveness and a range of experiences, with some reporting higher or lower levels. Responses to the *worthlessness* item revealed a mean value of 1.43 (*SD* = 1.17). It indicates that, on average, subjects reported experiencing feelings of worthlessness at a moderate level. While some individuals experience minimal feelings of worthlessness, others might report more severe symptoms (*BDI-II*; Beck, 1996).

Responses to the *Loss of energy* item revealed a mean score of 1.77 (*SD* = 1.01). This indicated a moderate level of energy loss. Responses to the *changes in sleeping patterns* revealed a mean value of 2.64 (*SD* = 2.22). This indicates moderate to severe changes in sleeping patterns, with high variability in the severity of sleep disturbances within this group. Overall, these findings underscore the pronounced impact of severe depression on sleep quality. Responses to the *irritability* item revealed a mean value of 1.57 (*SD* = 0.99). This indicates a moderate level of irritability. Responses to the *change in Appetite* items revealed a mean value of 2.47 (*SD* = 1.95). This indicates a severe level of change in Appetite, implying that individuals with severe depression may exhibit diverse patterns of appetite disturbance, ranging from minimal to significant alterations.

Responses to the *concentration difficulty* revealed a mean value of 1.62 (*SD* = 1.00). This indicates a relatively low level of concentration difficulty with only moderate variance among the subjects. Responses to the *tiredness* or fatigue item revealed a mean value of 2.40 (*SD* = 1.25). This indicates moderate levels of tiredness or fatigue, which

means that fatigue was a prominent symptom for individuals with severe depression. Responses to the *loss of interest in sex* items revealed a mean value of 1.85 (*SD* = 1.45). This indicated that, on average, individuals report a moderate level of loss of interest in sex. This variability highlights the diverse experiences of individuals concerning this specific symptom of depression. The overall mean score across all items provided a general indication of the average level of depressive symptoms experienced by the group. The standard deviations indicate the consistency of responses. Higher variability suggests that while some individuals may experience severe symptoms, others may not experience those symptoms as intensely. The mean scores for most items fall within the mild to moderate range, indicating that, on average, the participants experience mild to moderate depressive symptoms. The standard deviations suggest considerable variability in how these symptoms were experienced, with some individuals showing more severe symptoms. Overall, the findings indicated that the sample of Somali women in the United States exhibits mild to moderate levels of depression, with specific areas such as changes in sleeping patterns, changes in Appetite, tiredness, or fatigue, and loss of interest indicating higher severity.

Figure 1. Distribution graph indicating depression levels for different samples.



Anxiety

In order to test for the presence of anxiety, participants were asked to answer the *Generalized Anxiety Disorder Assessment-7* (*GAD-7*; Spitzer et al., 2006). Anxiety was a common experience among Somali women and subjects reported experiencing "elevated moderate anxiety per the scale norms *(M* = 11.40, *SD* = 5.19). This result confirmed the hypothesis that suggests that a notable level of anxiety was experienced among Somali women in the study sample. An item-level consideration of responses to the *GAD-7* can potentially shed light on the subjects' experience.

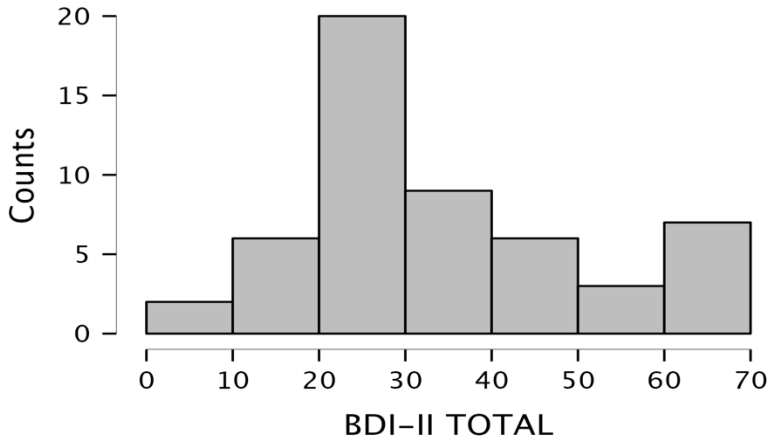
Responses to the *feeling nervous, anxious, or on edge* item revealed a mean value of 1.53 (*SD* = 1.01). This indicates, on average, respondents experience this symptom moderately level. Overall, these results highlight that this symptom is a common experience among the tested Somali women, with notable individual differences in its intensity. Responses to the *not being able to stop or control worrying* item revealed a mean value of 1.38 (*SD* = 0.95). This indicates that, on average, respondents experience this symptom between "several days" and "more than half the days" over the past two weeks.

The item revealed a mean value of 2.00 (SD = 1.06) in response to worrying too much about different things. This indicates moderate anxiety among the respondents and the results reflected a diverse range of worry intensity among individuals, with a central tendency towards moderate anxiety. Responses to the *trouble-relaxing* item revealed a mean value of 1.74 (*SD* = 1.00). This item on average, respondents report experiencing trouble relaxing to moderate levels of anxiety. Responses to the *Being so restless that it is hard to sit still* item revealed a mean value of 1.59 (*SD* = 1.01). This mean score indicates

that, on average, participants experienced restlessness to a degree that makes it hard for them to sit still somewhere between "several days" and "more than half the days" in the past two weeks. Overall, these results highlight that restlessness was a common symptom among the participants, affecting their ability to remain still, and this symptom's intensity varies among individuals.

Responses to *becoming easily annoyed or irritable* item revealed a mean value of 1.68 (*SD* = 1.02). This indicates that, on average, participants experience this symptom more than 'several days' but less than 'more than half the days which reflects a moderate anxiety indicating variability in how frequently participants feel easily annoyed or irritable. Responses to *feeling afraid, as if something awful might happen* item revealed a mean value of 1.68 (*SD* = 1.02). This indicates that, on average, individuals report experiencing moderate anxiety and feelings between "several days" (a score of 1) and "more than half the days" (a score of 2) over the past two weeks.

Figure 3. Distribution graph indicating anxiety levels for different samples.



Stress

In order to measure stress mood, subjects were asked to respond to the *Refugee Post-Migration Stress Scale (RPMS;* Malm et al., 2020). Stress was a possibly common

experience among Somali women and subjects reported experiencing “moderate stress” per the scale norms (*M* = 52.42, *SD* =16.9). This result confirmed the hypothesis that stress was common among Somali women in the sample. An item-level consideration of responses to the *RPMS* potentially sheds light on the subjects' experiences. Responses to the *discrimination by United States authorities* item revealed a mean value of 1.85 (*SD* = 1.18). The findings indicated that, on average, subjects report a moderate level of stress due to perceived or actual discrimination from U.S. authorities. The standard deviation suggested a notable variation in the stress levels experienced by different subjects, reflecting a diverse range of personal experiences and perceptions of discrimination within this group.

Responses to *discrimination in school or at work* items revealed a mean value of 2.23 (*SD* = 1.45). This indicates, on average, a moderate level of discrimination in school or at work among subjects. The standard deviation indicated a relatively high variability in responses, meaning that while some individuals experienced high levels of discrimination, others reported significantly lower levels. This wide range highlights the diverse experiences of participants in educational and workplace environments concerning discrimination. Responses to the *feeling disrespected due to national background* item revealed a mean value of 2.17 (*SD* = 1.45). This indicates a relatively moderate level of feeling disrespected due to national background. The standard deviation highlighted considerable variability in these experiences among the subjects, indicating that while some may feel little to no disrespect, others experience it much more.

Responses to *people making racist remarks towards me* item revealed a mean value of 2.11 (*SD* = 1.52). This indicates on average; subjects experience a low to moderate level of stress due to racist remarks. However, the relatively high standard deviation indicates significant variability in responses, implying that while some individuals may report minimal stress, others experience a much higher level of stress in response to racist remarks. This variability highlights the diverse impact of racial discrimination on post-migration stress among subjects.

Responses to the *bothering difficulties in communication in the United States* item revealed a mean value of 2.28 (*SD* = 1.47). This indicates a relatively moderate level of bothering difficulties in communication in the United States. Responses of *difficulties understanding how ordinary life activities in the United States work* item revealed a mean value of 2.85 (*SD* = 1.74). This indicates difficulty in understanding how ordinary life activities in the United States work (shopping, buying tickets, traveling, etc.) with moderate variance among the subjects. It reveals that while some Somali women adapt reasonably well, many find these activities quite challenging, as evidenced by the wide range of responses reflected in the standard deviation.

The question about difficulties understanding documents and forms from authorities revealed a mean value of 2.85 (*SD* = 1.73). This indicates that, on average, respondents experienced moderate difficulty understanding official documents and forms. The relatively high standard deviation implies considerable response variability, reflecting diverse participant experiences and perceptions. Responses to the *worry about an unstable financial situation* item revealed a mean value of 3.15 (*SD* = 1.68). This indicates a relatively moderate concern regarding their financial stability. The variation in

responses suggests that financial concerns significantly impact some individuals while others remain unaffected.

Responses to *frustration for not being able to support financial items* revealed a mean value of 2.81 (*SD* = 1.64). This indicates moderately high frustration related to being unable to financially support oneself. The result suggested that financial self-support was a significant stressor for many, but the intensity of this frustration can vary widely among different subjects. *Responses to the worries about debts* item revealed a mean of 2.68 (*SD* = 1.34). This indicates a moderate level of concern about financial obligations on average and considerable variation in the level of worry about debts among the subjects, with some experiencing significantly more stress than others regarding their financial liabilities.

Responses to *missing social life from back home* items revealed a mean value of 2.70 (*SD* = 1.65). This indicates a relatively moderate level of missing social life from back home, and the item was a common and varied stressor among Somali women. Responses to the *longing for my home country* item revealed a mean value of 2.72 (*SD* = 1.70). This indicates the subjects experienced a moderate level of longing for their home country. The standard deviation indicated a relatively high response variability, meaning that while some individuals may feel an intense longing, others may feel it much less. This result highlighted the diverse emotional experiences of subjects about their home countries after migration. Responses to the *missing activities they engaged in before coming to the United States* item revealed a mean value of 2.43 (*SD* = 1.65). This indicates a relatively moderate level of missing activities that they used to do before coming to the United States.

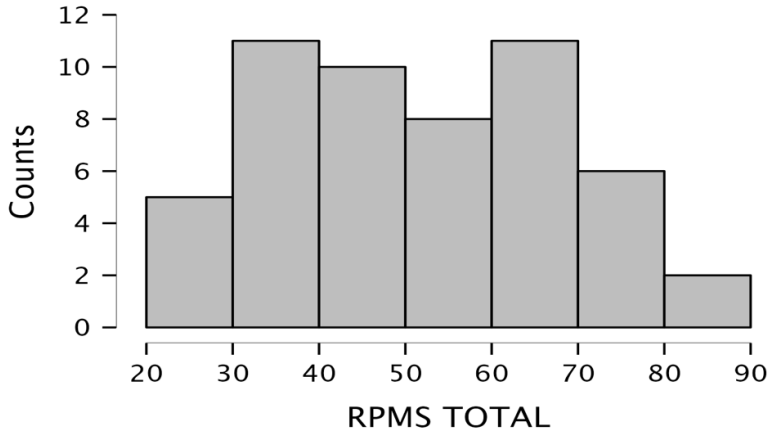
Responding to *worrying about family members being separated from* item revealed a mean value of 2.87 (*SD* = 1.69). Indicating that, on average, individuals reported a moderate concern regarding their separation from family members. The variation in responses reflects a range of experiences, with some individuals significantly affected by separation from family members while others are not concerned. Responses to *feeling sad because I am not reunited with family members* item revealed a mean value of 2.81(*SD* = 1.71). This indicated a moderate level of feeling sad because not reunited with family members. Responses to the *feelings excluded or isolated in United States society* item revealed a mean value of 2.06 (*SD* = 1.39). This indicates a relatively moderate level of feeling excluded or isolated in United States society among the subjects.

Responses to the *frustration due to loss of status in the United States society* item revealed a mean value of 1.85 (*SD* = 1.35). This indicates a moderate level of frustration due to the loss of status in the United States society after migration. The standard deviation suggests that the frustration levels vary significantly among individuals, reflecting diverse personal experiences and coping mechanisms in response to their change in status. The data indicates that subjects experienced significant frustration due to the inability to utilize their competencies after migrating to the United States. Responses to *frustration, because I cannot use my competencies in the United States* item, revealed a mean value of 2.09 (*SD* = 1.33). This indicates a relatively moderate level of frustration for not being able to make use of my competencies in the United among the subjects. This variation indicates that while some women may experience high frustration levels, others might feel less affected.

Responses of *distressing conflicts in my family* item revealed a mean value of 1.91 (*SD* = 1.21). This indicates that, on average, subjects experienced a low to moderate stress level from distressing conflicts with family after migration. Responses to *feeling disrespected in my family* item revealed a mean value of 1.94 (*SD* = 1.22). This indicates that, on average, subjects felt relatively low levels of disrespect within their family, but there was noticeable variability in their experiences, as indicated by the standard deviation. Responses to *feeling unimportant in my family* item revealed a mean value of 1.72 (*SD* = 0.97). This indicates that, on average, subjects experienced feeling unimportant to a relatively low degree. The standard deviation of this measurement indicated a moderate variation in how intensely individual subjects felt unimportant in their family settings

Responses to the *family and home country concerns* item revealed a mean value of 2.34 (*SD* = 1.52). This indicates an average stress level related to family and home country concerns, while the standard deviation indicated that the stress levels vary significantly among the subject population, reflecting a wide range of experiences and emotional responses.

Figure 2. Distribution graph indicating stress levels for different samples.



Summary

It was hypothesized that all three psychological factors (i.e., depression, anxiety, and stress) would correlate with the severity of trauma. Due to a procedural error, the severity of trauma was not directly measured among the subjects. However, an intercorrelation matrix was utilized to identify whether the relationship between the three psychological factors might reveal additional insight into Somali women's experiences. The results indicated severe depression mood, moderate stress, and elevated anxiety, a situation commonly found among survivors of trauma (Heeke et al., 2017).

Table 1

Descriptive Statistics and Correlation for Study Variables

		BDI-II	*GAD-7*	*RPMS*
BDI-II	Pearson's r	—		
	p-value	—		
GAD-7	Pearson's r		—	
	p-value	0.776	—	
		< .001		
RPMS	Pearson's r			
	p-value	0.622	0.578	—
		< .001	< .001	—

The descriptive statistics and correlations for the study variables are summarized in this Table. The correlation analysis Pearson's correlation coefficients (r) and corresponding p-values are provided to assess the relationships between variables. The data includes means and standard deviations for the above variables and the number of valid cases (N = 53). Pearson's correlation coefficients are provided for the relationships between age and the BDI-II, GAD-7, and RPMS scale totals, with corresponding p-

values. The relationship between age and these psychological measures was examined, and these findings highlight significant associations between age, depressive symptoms, anxiety, and post-migration stress in the sample population. These relationships underscore the importance of considering multiple psychological factors when assessing the mental health of refugee and immigrant populations.

CHAPTER V

DISCUSSION

Women affected by conflicts, displacement, and post-immigration difficulties continuously experience psychological and emotional challenges. These challenges stem from the trauma of conflict and displacement, compounded by the stress of adjusting to a new environment. Somali immigrant women living in Western nations have lower mental health service use than Somali men because the continuation of traditional gender principles builds barriers and prevents chances to look for mental health utilization (Næss, 2019). In addition, the isolated environment these women encounter in their adopted new countries makes them more likely to raise signs of depression and anxiety than women who have not experienced displacement or wars.

Many Somali women have experienced multiple traumas and have had a long-term impact of this distress during the war and while residing in their host countries because of a lack of social integration. Somali women were socially active in their homeland and always had commonality, connections, trust, and support from their female family members, neighbors, and other social networks (Guerin et al., 2006). However, after resettling to countries with different cultures and norms, their social relationship bonds with other Somali women have vanished (Guerin et al., 2006). Many women become more isolated than ever while experiencing more distress and frustration. Research by McMichael and Manderson (2004) found that the physical and collective circumstances of the settlement of Somalis in a new environment can make it very difficult to build the same social relationships they have in their homeland. Because their

new lives now define the means they can share with their relatives and friends and the level of interactions that can occur because of their busy lives.

Fear of stigmatization within their family members or communities around mental health concerns is another obstacle preventing mentally ill individuals from seeking professional support because of the negative pictures related to the name of the illness. Somali women's symbolic association with family accentuates perceived stigma and might contribute to collective and individual concealments. Somali women's cultural obligations and views within the family add to both collective and self-initiated strategies for mental health problem concealment (Næss, 2019). Somalis typically do not talk about mental health illnesses in public, making it difficult for individuals trying to seek help, especially women, who try to get treatment because of cultural pressure (Ahmed & Puglielli, 1988). Therefore, the intersection of past trauma and present-day stressors often leads to a range of mental health problems, including depression, anxiety, and stress (Feyera et al., 2015).

In addition, there are limited studies that explore the impact of depression, stress, and anxiety among Somali women in the United States. An understanding of the relationship between the underlying factors contributing to depression, stress, and anxiety and Somali women in the United States will assist in understanding the impact distress has on Somali women who live outside of their ancestor's homeland (Naess, 2019). This study explored the underlying factors contributing to mental health challenges among Somali women in the United States. Specifically, it explored the issues contributing to their psychological distress. Because Somali women have experienced significant trauma due to prolonged civil conflict, displacement, and the challenges of resettlement in a new

country, these experiences exacerbate mental health issues, making them a vulnerable group (Jorgenson et al., 2021; Heeke et al., 2017; Neuner, 2004).

Understanding the specific mental health needs of Somali women requires an in-depth exploration of their experiences both before and after migration. Consequently, this study explored the factors of mental health issues among 53 Somali women in the Upper Midwest of the United States. The results could probably be meaningful if more studies were conducted, and they can be crucial for developing effective mental health strategies. Addressing the underlying factors and enhancing access to culturally sensitive care can improve the mental health outcomes for Somali women and support their well-being.

Summary of the Findings

This study identified a high prevalence of depression among subjects. It exhibited some higher rates of depression compared to the general population, as evidenced by their scores on the validated scale, which provided quantifiable insights into their depression level, revealing that they experienced severe depression per their responses to the *Beck Depression Inventory (BDI-II;* Beck, 1996) measurement. Examining the underlying items contributing to depression suggested that depression related to conflict and refugee experiences remains very high among older age-tested subjects of the study who may experience both conflicts and post-migration problems.

The overall mean score across all items provided a general indication of the average level of depressive symptoms experienced by the group. The higher variability of the data suggests that while some individuals may experience severe symptoms, others may not experience those symptoms as intensely. While reviewing descriptive data on *BDI-II,* it appears similar to previous research (Mouanoutoua et al., 1991). The total

results of the Hmong women participants scale were (M = 46.66, SD = 10.15), which Mouanoutoua et al. (1991) study reported significantly more depression than men. These findings highlighted the significant impact of demographic factors such as education, language proficiency, and social support on depression levels among Hmong women refugees.

In the current study, specific areas such as changes in sleeping patterns, appetite changes, tiredness or fatigue, and loss of interest show higher severity. These findings highlighted the significant emotional distress and depressive symptoms experienced by this group, with notable variability in symptom severity across different individuals.

Identifying key factors that contributed to stress, our findings showed that Somali women face stress due to the combined pressures of acculturation, financial instability, family responsibilities, and experiencing some environmental stress. Acculturative stress was particularly significant, as Somali women struggle to balance maintaining their cultural identity with adapting to new societal norms in the U.S. Language barriers, cultural misunderstandings, and navigating different social expectations further compound their stress. Additionally, various aspects of daily life, including workplaces, schools, and public spaces, increase their stress levels (Veronis & McLeman, (2014).

Somali women in the study revealed elevated moderate stress symptoms, and it was common among Somali women in the sample. Stress was a possibly common experience among Somali women, and subjects reported almost all their questions experiencing "moderate stress." However, some respondents said they needed help understanding official documents and forms. The relatively high standard deviation implies considerable response variability, reflecting diverse participant experiences and perceptions. The

financial-related questions indicated moderately high frustration related to being unable to support oneself financially. Financial self-support was a significant stressor for many in the study, but the intensity of this frustration can vary widely among different subjects.

The study revealed a significant disparity in the subjects' worry about debts, with some experiencing significantly more stress than others regarding their financial liabilities. The findings also shed light on the diverse emotional experiences of the subjects about their home countries after migration. For instance, the worry about family members who were separated from them elicited a range of experiences, with some individuals deeply affected by the separation while others were less concerned. The sadness of not reuniting with their family was a common feeling, underscoring the emotional toll of such circumstances.

Anxiety was a prevalent issue among study subjects, as evidenced by their responses, which suggested that participants experienced elevated moderate anxiety. The study findings agree with the historical literature that indicates that being a Somali female may increase the odds of anxiety symptoms, which may lead to under-reported female mental health signs and may significantly increase the level of anxiety within these demographic subjects (Rask et al., 2016; Nielsen et al., 2015). Delving deeper into the responses reveals more nuanced insights into the nature of this anxiety.

In this present study, subjects experienced moderate anxiety, which was a shared experience among surveyed Somali women who reported experiencing elevated moderate anxiety per the scale norms. The result showed a notable level of anxiety experienced among Somali women in the study sample. The highest indicators for elevated moderate anxiety among subjects were worrying too much about different things, trouble relaxing,

and restlessness, which made it hard to sit still between "several days" and "more than half the days" in the past two weeks. Subjects revealed that these factors had affected their ability to remain still, with the intensity of this symptom varying among individuals.

The results reflected a diverse range of worry intensity among subjects. Although some subjects indicated that, on average, they experienced these symptoms at a moderate level, overall, the results highlighted that these symptoms were shared experiences among the tested Somali women, with significant individual differences in intensity. Overall, some of the symptoms of experienced elevated moderate anxiety items highlighted common problems, affecting their ability to remain still, with the intensity of this symptom varying among individuals.

Implications

In the present study, subjects reported severe depression mood, moderate stress, and elevated anxiety. Tested results by age showed older Somali women were significantly linked with higher levels of depression, which is believed to be deteriorated by the uncertainty and challenges of resettlement, including language barriers, discrimination, and the struggle to maintain cultural identity (Jorgenson et al., 2021). The stress and anxiety levels were to be elevated due to the compounded effects of these factors and additional pressures such as financial instability and responsibilities related to family and community.

The findings underscore the need for a nuanced understanding of the mental health challenges faced by Somali women, acknowledging the unique cultural and historical contexts that shape their experiences. Culturally competent care is needed to develop and implement culturally sensitive approaches to care. Understanding the unique

experiences and cultural backgrounds of Somali women in the United States is crucial in providing effective treatment for depression, anxiety, and stress. Training programs should include modules on cultural competence, focusing on Somali culture and the impact of trauma. Additionally, research and programs aimed at understanding and addressing the mental health challenges faced by Somali women are essential.

Strengths and Limitations

The current study provided a preliminary understanding of the severity of depression, stress, and anxiety in Somali female subjects. The strength of the research was that subjects were recruited in culturally relevant settings. This adaptation helped in accurately capturing the unique experiences of these Somali women.

Additionally, this study added new comprehension to the study of Somali women and mental health by revealing the trauma severities among these participants who represent several members of Somali women in the area. Although efforts were made to ensure cultural sensitivity, language barriers influenced participants' understanding and responses to survey questions. Translating research instruments into Somali helped mitigate this issue. While the study provides valuable insights into the mental health of Somali women in Minnesota, the findings may not be generalizable to Somali women beyond the Upper Midwest of the United States of America.

Future research should consider replicating the study in different contexts to enhance generalizability. The study focused on the presence of depression, anxiety, and stress. Other mental health issues were not explored in depth. A broader examination of various mental health conditions could provide a more comprehensive understanding of the challenges faced by Somali women. Undoubtedly, confounding variables were not

accounted for, such as previous mental health history or access to social support. These factors could influence the relationship between depression, stress, anxiety, and mental health outcomes.

Recommendation for Further Research

Following the outcomes of this study, conducting cross-sequential studies could provide a deeper understanding of the long-term effects of depression, stress, and anxiety among Somali women in the United States. Tracking changes over time will help to identify patterns and causal relationships that cross-sectional studies cannot. Future research should also consider the intersectionality of various identities like gender, history of living in the United States, and socioeconomic status and how these intersecting identities influence mental health outcomes. This approach will offer a clearer understanding of how different factors contribute to depression, stress, and anxiety. Expanding research to include diverse populations beyond Somali women will help generalize findings and identify unique challenges other immigrant women face. Comparative studies between different ethnic groups could also highlight cultural factors influencing mental health.

Second, investigating the effectiveness of trauma-informed interventions explicitly tailored for Somali women who have experienced significant trauma could provide valuable insights into how best to support this population. Evaluating different therapies will help determine the most effective strategies. Further research should explore the role of social support networks, including family, community, and institutional support, in mitigating depression, stress, and anxiety. Understanding the dynamics of social support can inform the development of programs that strengthen these

networks. Studies focusing on the impact of acculturation and cultural adaptation on mental health among immigrant women are crucial. Research should examine how adapting to a new culture affects stress levels and mental health outcomes and identify protective factors that facilitate better adjustment.

Third, research should investigate the impact of policies and structural factors, such as immigration laws, healthcare access, and economic opportunities, on the mental health of immigrant women. Identifying barriers and facilitators at the policy level can inform advocacy and policy change. Employing other research methods, such as a mixed method or qualitative, can provide deeper insights into the lived experiences of Somali women dealing with depression, stress, and anxiety. These methods can uncover personal narratives and contextual factors that quantitative data may overlook. Future studies should compare the effectiveness of various mental health interventions tailored to Somali women. Understanding which interventions are most effective for specific populations can guide clinical practice and resource allocation.

Finally, exploring the potential of mental health group meetings, social gathering workshops, and online support groups could provide accessible solutions for Somali women experiencing mental health issues. Research should assess the feasibility, acceptability, and effectiveness of these interventions. Investigating depression, stress, and anxiety among Somali young women and adolescents, particularly those in immigrant families, is essential. Early intervention and prevention strategies can be developed to address mental health issues and stigma before they become more severe in adulthood. Future research should explore the impact of reproductive health issues, gender-based violence, and societal expectations on Somali women's mental health. By

addressing these areas, future research can provide a more comprehensive understanding of depression, stress, and anxiety among Somali women and contribute to the development of effective interventions and policies to support their mental health.

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APPENDIX A: INFORMED CONSENT (ENGLISH)

MENTAL HEALTH AMONG SOMALI WOMEN IN THE UNITED STATES

(Minnesota State University, Mankato)

INFORMED CONSENT

IRBNet# 2161978

INTRODUCATION

You are invited to participate in a survey about how depression, stress, and anxiety may affect Somali women. The goal of this study will be to measure the experience of depression, stress, and anxiety for Somali women in the United States. This study is being conducted as part of Khadra Hussien's (khadra.hussien@mnsu.edu) doctoral dissertation under the advising of Prof. Jason Kaufman (Jason.kaufman@mnsu.edu) in the Educational Leadership Department at Minnesota State University, Mankato.

PROCEDURE

If you agree to participate, you will respond to a survey asking questions about your experiences with depression, stress, and anxiety. The survey should take 15-20 minutes to complete. Your responses will be anonymous.

POTENTIAL RISKS OF PARTICIPATION

Participating in the project carries risks no greater than those in everyday life. However, some questions may make you feel uncomfortable. If that happens, you can skip those questions or withdraw from the study altogether.

POTENTIAL BENEFITS OF PARTICIPATION

There are no tangible benefits to participating in the study.

STATEMENT OF CONFIDENTIALITY

All information obtained in this research project will be kept private by Khadra Hussien and Prof. Jason Kaufman (Advisor). All information will be stored in a safe site, limiting who can see your response data and safeguarding your privacy. Therefore, the data will be kept in a secure platform service that provides encryption, data protection, and privacy policies like Qualtrics and Google Forms. All other materials will be coded to protect your identity. If you want more information about the privacy and anonymity risks of online surveys, please contact the Minnesota State University, Mankato IT Solutions Center (507-389-6654) and ask to speak to the Information Security Manager.

VOLUNTARY NATURE OF THE STUDY

Your decision to participate in this study will not affect your current or future relationship with the researcher and will not affect your relationship with Minnesota State University, Mankato, and refusal to participate will involve no penalty or loss of benefits. If you decide to participate, you are free to withdraw from this project at any time by not returning your responses.

CONTACTS AND QUESTIONS

If you have any questions about this research study, contact Khadra Hussien at 612-423-2542 or khadra.hussien@mnsu.edu or the Principal Investigator Prof. Jason Kaufman at 952-818-8877 or Jason.kaufman@mnsu.edu If you have any questions about this research study, contact (Principal Investigator) at 952-818-8877 or Jason.kaufman@mnsu.edu). If you have any questions about participants' rights and research-related injuries, please contact the Director of the Institutional Review Board at 507-389-1242 or irb@mnsu.edu.

STATEMENT OF CONSENT

"I have read this consent form and voluntarily consent to participate. I am 18 years old or older. By saying "yes," I indicate my willingness to participate in the study voluntarily. The researchers have answered all my questions concerning this research. A copy of this form has been offered to me.

Yes_____

No_____

Demographics

Please answer the following demographics questions as accurately and honestly as possible.

Do you identify as female?

Yes____

No____

Do you identify as Somali?

Yes____

No____

Please tell us your current age:
I am _____

Note: You are welcome to request a copy of this consent form for your records.

APPENDIX B: INFORMED CONSENT (SOMALI)

CAAFIMAADKA MASKAXDA EE HAWEENKA SOOMAALIYEED EE KU NOOL MAREYKANKA

(Minnesota State University, Mankato)

OGOLAANSHAHA XOG-URURINTA

IRBNet# 2161978

HORDHAC

Waxaa lagugu martiqaadayaa inaad ka qaybqaadato daraasad ra'yi arurin ah oo ku saabsan sida murugada, walwalka iyo walaacu ay u saameeyaan haweenka Soomaaliyeed. Hadafka daraasaddan ayaa noqon doona in la cabiro dareenka khibrada murugada, walwalka iyo walaaca haweenka Soomaaliyeed ee ku nool Mareykanka. Daraasaddan waxay qayb ka tahay Khadra Hussien (khadra.hussien@mnsu.edu) qalin-jabinteeda takhakhuska barnaamijka dhakhtarnimo oo hoos timaada la taliyaheeda Prof. Jason Kaufman (jason.kaufman@mnsu.edu) ee Waaxda Hogaaminta Waxbarashada ee Jaamacadda Gobolka Minnesota, Mankato.

NIDAAMKA LA RAACAYO
Haddii aad ogolaato inaad ka qaybgasho, waxaad ka jawaabi doontaa ra'yi ururin lagugu waydiinayo su'aalo ku saabsan khibradahaaga murugada, walwalka iyo walaaca. Sahanku wuxuu qaadanayaa 15-20 daqiiqo dhamaystirkiisu. Jawaabahaagu waxay noqon doonaan qarsoodi.

KHATARTA SUURTAGALKA AH EE KA QAYB-QAADASHADA
Ka qayb-qaadashada mashruuca waxay xambaarsan tahay khataro aan ka weynayn kuwa nolol maalmeedka. Su'aalaha qaarkood ayaa laga yaabaa inay dareenkaaga kiciyaan. Haddii taasi dhacdo, waad ka boodi kartaa su'aalahaas ama waad ka bixi kartaa gabi ahaanba daraasadda.

FAA'IIDOOYINKA SUURTAGALKA AH EE KA QAYB-QAADASHADA Ma jiraan faa'iidooyin la taaban karo oo ku jira ka qaybqaadashada daraasadda.

BAYAANKA QARINTA XOGTA
Dhammaan akhbaaraadka laga aruuriyo mashruucan cilmi-baarista ah waxaa si qarsoodi ah u ilaalin doona Khadra Hussien iyo Prof. Jason Kaufman (La taliyaheeda). Dhammaan macluumaadka waxaa lagu kaydin doonaa goob ammaan ah oo xaddidaysa cidda arki karta xogta jawaabtaada iyo ilaalinta sirtaada. Sidaa darteed, xogta waxaa lagu hayn doonaa adeeg madal sugan ah oo lagu ilaaliyo xogta, iyo siyaasadaha khaaska ah sida Qualtrics iyo Google Forms. Haddii aad rabto macluumaad dheeraad ah oo ku saabsan xafidida xogta iyo khataraha xog ururinta online ka ah, fadlan la xidhiidh Jaamacadda Gobolka Minnesota, Xarunta Xallinta IT ee Mankato (507-389-6654) oo weydii inaad la hadasho Maareeyaha Amniga Macluumaadka.

NOOCA ISKAA-WAX -UQABSO EE DARAASADDA

Go'aankaaga ka qaybqaadashada daraasaddan ma saameyn doonto xiriirka aad hadda ama mustaqbalka la leedahay cilmi-baadhaha ama xiriirka aad la leedahay Jaamacadda Gobolka Minnesota, Mankato, diidmada ka qeybqaadashaduna kuma lug yeelan doonto ganaax ama waayitaan dheefo. Haddii aad go'aansato inaad ka qaybgasho, xor ayaad u tahay inaad ka baxdo xog aruurinta wakhti kasta adiga oo aan soo celin jawaabahaaga.

XIRIIRKA IYO SU'AALAHA AAD QABTO

Haddii aad wax su'aalo ah ka qabto daraasaddan cilmi-baarista ah, kala xiriir Khadra Hussien 612-423-2542 khadra.hussien@mnsu.edu ama Prof. Jason Kaufman 952-818-8877 ama jason.kaufman@mnsu.edu. Haddii aad wax su'aalo ah ka qabto daraasaddan cilmi-baarista, la xiriir (Baaraha Maamulaha) 952-818-8877 ama Jason.kaufman@mnsu.edu. Haddii aad hayso wax su'aalo ah oo ku saabsan xuquuqda ka qaybgalayaasha iyo walaac cilmi-baarista la xiriira, fadlan kala xiriir Agaasimaha Guddiga Dib-u-eegista Hay'adaha 507-389-1242 ama irb@mnsu.edu.

BAYAANKA OGOLAANSHAHA

Waan akhriyay warqadan oggolaansha ah waxaana si ikhtiyaarkayga ah aan u oggolaaday inaan ka qaybqaato daraasadda. Waxaan ahay 18 jir ama waan ka weynahay. Doorashadayda "Haa" waxaay cadaynaysaa inaan ogalaaday si ikhtiyaari ah inaan uga qayb qaato daraasadda. Cilmi-baadhayaashu waay ka jawaabeen dhammaan su'aalahaygii ku saabsanaa cilmi-baadhistan. Nuqul ka mid ah waraqadana waa la ii soo bandhigay.

Haa_____

Maya_____

TIRAKOOBKA DADWEYNAHA

Fadlan uga jawaab su'aalaha soo socda sida ugu macquulsan ee saxda ah.

Ma cadaynaysaa inaad dumar tahay?

Haa____

Maya____

Ma cadaynaysaa inaad Soomaali tahay?

Haa____

Maya____

_____

Fadlan noo sheeg da'dda aad hadda jirto:

Waxaan Jiraa _____

Fiiro gaar ah: Waad codsan kartaa nuqul ka mid ah foomkan ogolaanshaha xogtaada.

APPENDIX C: BDI-II (ENGLISH)

Subject #:_____

BDI-II

Below is a list of common symptoms of depression. Please read each groups statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you picked. Be sure that you do not choose more than one statement for any group.

1. Sadness
0. I do not feel sad.
1. I feel sad much of the time.
2. I am sad all the time.
3. I am so sad or unhappy that I can't stand it.

2. Pessimism
0. I am not discouraged about my future.
1. I feel more discouraged about my future than I used to.
2. I do not expect things to work out for me.
3. I feel my future is hopeless and will only get worse.

3. Past Failure
0. I do not feel like a failure.
1. I have failed more than I should have.
2. As I look back, I see a lot of failures.
3. I feel I am a total failure as a person.

4. Loss of Pleasure
0. I get as much pleasure as I ever did from the things I enjoy.
1. I don't enjoy things as much as I used to.
2. I get very little pleasure from the things I used to enjoy.
3. I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
0. I don't feel particularly guilty.
1. I feel guilty over many things I have done or should have done.
2. I feel quite guilty most of the time.
3. I feel guilty all the time.

6. Punishment Feelings
0. I don't feel I am being punished.
1. I feel I may be punished.
2. I expect to be punished.
3. I feel I am being punished.

7. Self-Dislike
0. I feel the same about myself as ever.
1. I have lost confidence in myself.
2. I am disappointed in myself.
3. I dislike myself.

8. Self-Criticalness
0. I don't criticize or blame myself more than usual.
1. I am more critical of myself than I used to be.
2. I criticize myself for all of my faults.
3. I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
0. I don't have any thoughts of killing myself.
1. I have thoughts of killing myself, but I would not carry them out.
2. I would like to kill myself.
3. I would kill myself if I had the chance.

10. Crying
0. I don't cry any more than I used to.
1. I cry more than I used to.
2. I cry over every little thing.
3. I feel like crying, but I can't.

11. Agitation
0. I am no more restless or wound up than usual.
1. I feel more restless or wound up than usual.
2. I am so restless or agitated, it's hard to stay still.
3. I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
0. I have not lost interest in other people or activities.
1. I am less interested in other people or things than before.
2. I have lost most of my interest in other people or things.
3. It's hard to get interested in anything.

13. Indecisiveness
0. I make decisions about as well as ever.
1. I find it more difficult to make decisions than usual.
2. I have much greater difficulty in making decisions than I used to.
3. I have trouble making any decisions.

14. Worthlessness
0. I do not feel I am worthless.
1. I don't consider myself as worthwhile and useful as I used to.
2. I feel more worthless as compared to others.
3. I feel utterly worthless.

15. Loss of Energy
0. I have as much energy as ever.
1. I have less energy than I used to have.
2. I don't have enough energy to do very much.
3. I don't have enough energy to do anything.

16. Changes in Sleeping Pattern
0. I have not experienced any change in my sleeping.
1a. I sleep somewhat more than usual.
1b. I sleep somewhat less than usual.
2a. I sleep a lot more than usual.
2b. I sleep a lot less than usual.
3a. I sleep most of the day.
3b. I wake up 1-2 hours early and can't get back to sleep.

17. Irritability
0. I am not more irritable than usual.
1. I am more irritable than usual.
2. I am much more irritable than usual.
3. I am irritable all the time.

18. Changes in Appetite
0. I have not experienced any change in my appetite.
1a. My appetite is somewhat less than usual.
1b. My appetite is somewhat greater than usual.
2a. My appetite is much less than before.
2b. My appetite is much greater than usual.
3a. I have no appetite at all.
3b. I crave food all the time.

19. Concentration Difficulty
0. I can concentrate as well as ever.
1. I can't concentrate as well as usual.
2. It's hard to keep my mind on anything for very long.
3. I find I can't concentrate on anything.

20. Tiredness or Fatigue
0. I am no more tired or fatigued than usual.
1. I get more tired or fatigued more easily than usual.
2. I am too tired or fatigued to do a lot of the things I used to do.
3. I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex
0. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I am much less interested in sex now.
3. I have lost interest in sex completely.

APPENDIX D: BDI-II (SOMALI)

Ka qaybqaataha #_____

BDI-II

Hoos waxaa ku qoran liiska calaamadaha lagu garto murugada ama niyad-jabka. Fadlan si taxadar leh u akhri qoraalka koox kasta, ka dibna koox kasta ka soo xulo hal qoraal oo si fiican u qeexaya sida aad dareemaysay labadii toddobaad ee la soo dhaafay, oo ay ku jirto maanta. Goobaabi lumbarka u dhaw qoraalka aad dooratay. Hubi inaadan kooxna ka dooran wax ka badan hal qoraal.

1. Murugo
0. Ma dareemayo murugo.
1. Waxaan dareemaa murugo waqti badan.
2. Mar walba waan murugoodaa.
3. Si aad ah ayaan u murugaysanahay ama aanana u faraxsanayn oo aanan u adkaysan karin.

2. Jahwareer
0. Kaman niyad jabin mustaqbalkayga.
1. Waxaan dareemaa niyad jab badan oo ku saabsan mustaqbalkayga oo aanan horey u daareemi jirin.
2. Ma filayo in arrimaha aan doonayo ay ii hirgalaan.
3. Waxaan dareemayaa in mustaqbalkaygu rajo la'aan yahay oo uu ka sii dari doono.

3. Guul-darro hore
0. Ma dareemayo inaan guul-darraystay.
1. Wax badan ayaan guul-daraystay.
2. Markaan dib u milicsado, waxaan arkaa Guul-darrooyin badan.
3. Waxaan dareemayaa inaan ahay qof guud ahaan guuldaraystay.

4. Waayitaanka Farxada
0. Farxad badan ayaan ka helaa waxyaabahaan raaxada waligay ka heli jiray.
1. Waxyaabo badan oo aan horey u samayn jiray ayaanan hada ku raaxaysan.
2. Wax yar oo farxad ah ayaan ka helaan waxyaabo badan oo aan ku raaxaysan jiray.
3. Wax farxad ah kama helo waxyaabihii aan ku raaxaysan jiray.

5. Dareen Dam-biile
0. Ma dareemayo eed gaar ah.
1. Waxaan dareemaa in aan danbiyo ka galay waxyaabo badan oo aan sameeyay ama ay ahayd in aanan sameeyn.
2. Inta badan waxaan dareemaa in aad dambi galay.
3. Naftayda ayaan eedeeyaa inta badan.

6. Dareemida Ciqaabta
0. Ma dareemayo in la i ciqaabayo.
1. Waxaan dareemayaa in la i ciqaabi doono.
2. Waxaan filayaa in la i ciqaabo.
3. Waxaan dareemayaa in la i ciqaabay.

7. Is-nacayb
0. Waxaan dareemayaa sidaan weligay ahaa.
1. Kalsoonid aan qabay ayaa iga luntay.
2. Nafteyda waan ka niyad jabay.
3. Naftayda waan necbahay.

8. Is dhaleecayn
0. Anigu naftayda ma canaanto, mana eedeeyo in ka badan sida caadiga ah.
1. Si ka badan sidii hore ayaan u eedeeyaa naftayda.
2. Khalad kasta oo aan sameeyo naftayda ayaa ku eedeeyaa.
3. Wax kasta oo xumaan ah oo dhaca ayaan naftayda ku eedeeyaa.

9. Ku fakarid ama rabitaan is-dilid
0. Kuma fikiro inaan is dilo.
1. Waxaan ku fakara inaan is dilo, laakiin ma samayn karo.
2. Waxaan jeclaan lahaa inaan is dilo.
3. Waan is dili lahaa haddaan fursad u heli lahaa.

10. Oohin
0. In ka badan sidii hore uma ooyo.
1. Wax kabadan sidii hore ayaan ooyaa.
2. Wax kasta oo yar ayaan u ooyaa.
3. Waxaan dareemayaa inaan ooyo, laakiin ma awoodo.

11. Dareen
0. Walaac owgiis nasasho la'aan ma lahi mana ka xanaaq badni sidii hore.
1. Waxaan dareemaa walaac iyo xanaaq ka badan sidii cadiga ahayd.
2. Aad ayaan u walaacsanahay una xanaaqsanahay oo way igu adagtahay inaan is celiyo.
3. Aad ayaan u walaacsanahay una xanaaqsanahay waxaan rabaa inaan socdo ama wax sameeyo.

12. Xiiso Dhac
0. Xiisihii aan u qabay howlaha iyo dadka kale igama lumin.
1. Si ka yar sidii hore ayaan u xiiseeyaa dadka iyo waxyaabaha kale.
2. Inta badan xiisihii aan u qabay dadka iyo waxaayabaha kale way iga lumeen.
3. Way adag tahay inaad wax xiisayso.

13. Go'aan la'aan
0. Waligay go'aamo sax ah ayaan qaataa.
1. Waxaa igu adag inaan go'aan gaaro sida caadiga ah.
2. Waxaa igu adag inaan qaato go'aamadii aan qaadan jiray oo kale.
3. Way igu adagtahay inaan go'aan gaaro.

14. Qiimo la'aan
0. Ma dareemayo inaan qiimo leeyahay.
1. Uma arko naftayda mid qiimo leh oo waxtar leh sidii aan ahaan jiray.
2. Waxa aan dareemaa in aan qiimo lahayn marka la barbardhigo kuwa kale.
3. Waxaan dareemayaa wax aan qiimo lahayn.

15. Awood la'aan
0. Fir fircooni badan oo aanan horey u lahayn ayaa igu jirta.
1. Fir fircooni ka yar tii aan horey u lahaa ayaa igu jirta.
2. Ma lehi firfircooni igu filan oo aan wax badan ku qabto.
3. Ma haysto tamar igu filan oo aan wax ku sameeyo.

16. Isbeddelka Qaabka Hurdada
0. Wax isbaddel ah kalama kulmin hurdadayda.
1a. Waxaan seexdaa wax ka badan sidii caadiga ahayd.
1b. Waxaan seexdaa wax ka yar sidii caadiga ahayd.
2a. Waxaan seexdaa wax ka badan sidii caadiga ahayd.
2b. Waxaan seexdaa wax aad uga yar sidii caadiga ahayd.
3a. Waxaan seexdaa inta badan maalinta oo dhan.
3b. Waxaan toosaa 1-2 saacadood ka hor kumana noqon karo hurdadda.

17. Xanaaq
0. Kama xanaaq badni sida caadiga ah.
1. Waan ka xanaaq badanahay sida caadiga ah.
2. Aad ayaan uga xanaaq badanahay sidii caadiga ahayd.
3. Had iyo jeer waan xanaaqaa.

18. Isbeddel ku yimaada rabitaanka cuntada
0. Wax isbeddel ah kuma imaan rabitaanka cuntadayda.
1a Rabitaankaygu waa ka yara yar yahay sidii caadiga ahayd.
1b Rabitaankaygu waa ka yara weyn yahay sidii caadiga ahayd.
2a Rabitaankaygu aad buu uga yar yahay sidii hore.
2b Rabitaankaygu aad buu uga weyn yahay sidii caadiga ahayd.
3a Haba yaraatee wax niyad ah uma hayo cunto.
3b Waxaan doonaa cunto mar walba.

19. Ku adkaanta waxyaabaha xoog la saaro
0. Wax xoog waan saari karaa sidii hore oo kale.
1. Waxba xooga ma saari karo sidii hore oo kale.
2. Way adag tahay inaan wax maskaxdayda ku hayo wakhti badan.
3. Waxaan ogaaday inaanan waxba xoog saari karin.

20. Daal ama Noog
0. Kama daal badni sidii hore.
1. Si ka fudud sidii hore oo aanan u daali jirin ayaan u daalaa.
2. Wax yaabo badan oo aan samayn jiray ayaan hada ka noogaa inaan sameeyo.
3. Aad ayaan u daalanahay oo ma samayn karo waxyaalihii aan samayn jiray.

21. Luminta Xiisaha Galmada

0. Madareemin wax is bedel ah oo ku yimi dareenkayga galmada.
1 Sidaan horey u xiiseeyn jiray hada uma xiiseeyo.
2. Aad ayaan u xiiseeyaa isu taga hadda.
3. Waxaan lumiyay xiisaha galmada gabi ahaanba.

APPENDIX E: RPMS (ENGLISH)

Subject#:_____

RPMS

Instructions: For each of the following, please rate the extent to which you agree with each statement, using the scale from 1 to 5 as shown below. Please respond as you really feel, rather than how you think "most people" feel.

1 **Disagree strongly**	2 **Disagree a little**	3 **Neither agree nor disagree**	4 **Agree a little**	5 **Agree strongly**

1. Discrimination by United Stated authorities. ____
2. Discrimination in school or at work ____
3. Feeling disrespected due to my national background ____
4. People making racist remarks towards me ____
5. Bothering difficulties communicating. in the United States. ____
6. Difficulties understanding how ordinary life activities in the United States work (shopping, buying tickets, traveling, etc. ____
7. Worry about unstable financial situation. ____
8. Frustration for not being able to support myself financially. ____
9. Worry about debts. ____
10. Missing my social life from back. Home. ____
11. Longing for my home country ____
12. Difficulties understanding documents and forms from authorities. ____
13. Missing activities that I used to do before coming to the United States. ____
14. Worry about family members that I am separated from. ____
15. Feeling sad because I am not reunited with family members. ____
16. Feeling excluded or isolated in the United States society. ____
17. Frustration due to loss of status in the United States society. ____
18. Frustration because I am not able to make use of my competences in the United States. ____
19. Distressing conflicts in my family. ____
20. Feeling disrespected in my family. ____
21. Feeling unimportant in my family. ____
22. Family and home country concerns. ____

APPENDIX F: RPMS (SOMALI)

Ka Qaybgale#:_____

RPMS

Tilmaamaha: Mid kasta oo ka mid ah su'aalaha soo socda, fadlan qiimee ilaa inta aad ku raacsan tahay, adoo isticmaalaya cabbirka 1 ilaa 5 sida hoos ku cad. Fadlan uga jawaab su'aal walba sida aad dhab ahaantii dareemayso, halkii aad oran lahayd "dadka badankiisu" waxay dareemayaan.

1 Si xoog leh u khilaafsan	2 Wax yar Khilaafsan	3 Kumana raacsani kumana khilaafsani	4 Wax yar ayaan ku raacsanahay	5 Si xoog leh ayaan ugu raacsanahay

1. Midab takoor ka dhex jira maamulka Maraykanka. ____
2. Midab kala sooc ayaa ka jira dugsiga ama shaqada. ____
3. Waxaan dareemaa xushmo daro meesha aan ka soo jeedo darteed. ____
4. Dad ayaa si cunsurinimo ah hadalo tacliiq ah iigu dhaha. ____
5. Dhibaatooyin xaga xiriirka ah oo adag ayaa ka jirta Maraykan. ____
6. Is fahan xumo la xiiirta sida nolosha caadiga ah ee dadka Maraykanku u shaqayso ayaa jirta (dukaamaysiga, iibsashada tigidhada, socdaalka, iwm.) ____
7. Ka walwal dhinaca dhaqaalaha ah oo aan xasilloonayn ayaa jirta. ____
8. Niyad-jab ah inaanan awoodin in aan naftayda taageero dhaqaale ahaan ayaa jirta. ____
9. Waxaan ka walwalaa deymo. ____
10. Waxaan u xiisay noloshii aan ku haystey wadankaygii hooyo. ____
11. Waan u hiloowey dalkaygii hooyo ____
12. Waay igu adag tahay inaan fahmo warqadaha ama foomamka ka yimaada dowlada. ____
13. Waan u hilooway waxyaabihii aan qaban jiray intii aanan imaan Maraykan. ____
14. Waxan ka walwalaa qayb ka mid ah qoyskagya oo aan kala maqan nahay. ____
15. Waxaan dareemayaa murugo sababtoo ah dib ulama kulmin qaar ka mid ah qoyskagya. ____
16. Waxaa ku dareemayaa Maraykanka cidlo iyo ka soocnaan. ____
17. Waxaan dareemayaa niyad-jab la la xariirta ku dhex noolaanshaha bulshada ku dhaqan Maraykanka, ____
18. Niyad-jab ayaan dareemayaa sababtoo ah awood xirfadeed kuma lihi bulshada Maraykanka dhexdeeda. ____
19. Khilaaf dhibaato leh ayaa ka dhex jira qoyskayga. ____
20. Xushmo daro ayaan kala kulmaa qoyskayga. ____
21. Muhiimad kuma dhex lihi reerkayga. ____
22. Wal wal qoyska iyo dalkaygii hooyo ah ayaa i haysta. ____

APPENDIX G: GAD-7 (ENGLISH)

Subject #:_____

GAD-7 Anxiety

Please choose one answer for each of the 7 questions below:

Over the last two weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it is hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid, as if something awful might happen.	0	1	2	3

APPENDIX H: GAD-7 (SOMALI)

Subject #:_____

GAD-7 Walaaca

Fadlan ka dooro hal jawaab todobadaan su'aalood ee hoos ku qoran:

Labadii toddobaad ee u dambeeyay, immisa jeer ayey ku dhibeen dhibaatooyinkan soo socda?	**Marna haba yaraatee**	**Maalmo badan**	**In ka badan kala badh maalmaha**	**Ku dhawaad maalin kasta**
1. Waxaan dareemaa walwal, walaac, ama inaan qar ka dhacayo.	0	1	2	3
2. Awood la'aan aan walaaca lagu joojin karin ama aan lagu koobi karin.	0	1	2	3
3. Walaac badan oo ku saabsan waxyaabo kala duwan.	0	1	2	3
4. Dhibaato nasasho la'aan ah.	0	1	2	3
5. Nasasho la'aan keenta in fariisigu adkaado.	0	1	2	3
6. Inaad si fudud u xanaaqdid ama u carootid.	0	1	2	3
7. Dareen cabsiyeed oo ah in wax xun ay dhici karaan.	0	1	2	3

APPENDIX I: IRB LETTER

April 15, 2024

Re: IRB Proposal [2161978-3] Somali Women and Trauma
Review Level: Exempt (Level I)

Congratulations! Your Institutional Review Board (IRB) Proposal has been approved as of April 15, 2024.

On behalf of the Minnesota State University, Mankato IRB, we wish you success with your study. Please remember that you must seek approval for any changes in your study, its design, funding source, consent process, or any part of the study that may affect participants in the study (https://research.mnsu.edu/institutional-review-board/proposals/process/proposal-revision/).

Should any of the participants in your study suffer a research-related injury or other harmful outcomes, you are required to report them immediately to the Associate Vice-President for Research and Dean of Extended Campus at 507-389-1242.

When you complete your data collection or should you discontinue your study, you must submit a Closure request. All documents related to this research must be stored for a minimum of three years following the date on your Closure request (https://research.mnsu.edu/institutional-review-board/proposals/process/proposal-closure/).

If the PI leaves the university before the end of the 3-year timeline, he/she is responsible for ensuring proper storage of consent forms (https://research.mnsu.edu/institutional-review-board/proposals/process/leaving-campus/). Please include your IRBNet ID number with any correspondence with the IRB.

Be well,

Jeffrey Buchanan, Ph.D.
Co-Chair of the IRB

Chelsea Mead, Ph.D.
Co-Chair of the IRB

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Minnesota State University, Mankato IRB's records.

APPENDIX J: QUALTRICS QUESTIONNAIRE(ENGLISH)

Q2 **MENTAL HEALTH AMONG SOMALI WOMEN IN THE UNITED STATES**

(Minnesota State University, Mankato)

INFORMED CONSENT

IRBNet# 2161978

INTRODUCTION

You are invited to participate in a survey about how depression, stress, and anxiety may affect Somali women. The goal of this study will be to measure the experience of depression, stress, and anxiety for Somali women in the United States. This study is being conducted as part of Khadra Hussien's (khadra.hussien@mnsu.edu) doctoral dissertation under the advising of Prof. Jason Kaufman (Jason.kaufman@mnsu.edu) in the Educational Leadership Department at Minnesota State University, Mankato.

PROCEDURE

If you agree to participate, you will respond to a survey asking questions about your experiences with depression, stress, and anxiety. The survey should take 15-20 minutes to complete. Your responses will be anonymous.

POTENTIAL RISKS OF PARTICIPATION

Participating in the project carries risks no greater than those in everyday life. However, some questions may make you feel uncomfortable. If that happens, you can skip those questions or withdraw from the study altogether.

POTENTIAL BENEFITS OF PARTICIPATION

There are no tangible benefits to participating in the study.

STATEMENT OF CONFIDENTIALITY

All information obtained in this research project will be kept private by Khadra Hussien and Prof. Jason Kaufman (Advisor). All information will be stored in a safe site, limiting who can see your response data and safeguarding your privacy. Therefore, the data will be kept in a secure platform service that provides encryption, data protection, and privacy policies like Qualtrics and Google Forms. All other materials will be coded to protect your identity. If you would like more information about the specific privacy and anonymity risks by online surveys, please contact the Minnesota State University, Mankato IT Solutions Center (507-389-6654) and ask to speak to the Information Security Manager.

VOLUNTARY NATURE OF THE STUDY

Your decision to participate in this study will not affect your current or future relationship with the researcher and will not affect your relationship with Minnesota State University,

Mankato, and refusal to participate will involve no penalty or loss of benefits. If you decide to participate, you are free to withdraw from this project at any time by closing your browser.

CONTACTS AND QUESTIONS
If you have any questions about this research study, contact Khadra Hussien at 612-423-2542 or khadra.hussien@mnsu.edu or the Principal Investigator Prof. Jason Kaufman at 952-818-8877 or Jason.kaufman@mnsu.edu. If you have any questions about this research study, contact Professor Jason Kaufman at 952-818-8877 or jason.kaufman@mnsu.edu. If you have any questions about participants' rights and for research-related injuries, please contact the Director of the Institutional Review Board at 507-389-1242 or irb@mnsu.edu.
Note: You are welcome to print a copy of this consent form for your records.

STATEMENT OF CONSENT
"I have read this consent form and voluntarily consent to participate. I am 18 years old or older. By saying "yes," I indicate my willingness to voluntarily take part in the study. The researchers have answered all of my questions concerning this research.

- ○ Yes (1)
- ○ No (2)

Q31 Please answer the following demographics questions as accurately and honestly as possible.

Q29 Do you identify as female?

- ○ Yes (1)
- ○ No (2)

Q30 Do you identify as Somali?

- ○ Yes (1)
- ○ No (2)

Q32 Please tell us your current age:
I am.....

0 10 20 30 40 50 60 70 80 90 100

Age in years ()	

Instructions Below is a list of common symptoms of depression. Please read each groups statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Be sure that you do not choose more than one statement for any group.

Q7 1. Sadness

- I do not feel sad. (1)
- I feel sad much of the time. (2)
- I am sad all the time. (3)
- I am so sad or unhappy that I can't stand it. (4)

Q8 2. Pessimism

- I am not discouraged about my future. (1)
- I feel more discouraged about my future than I used to. (2)
- I do not expect things to work out for me. (5)
- I feel my future is hopeless and will only get worse. (4)

Q9 3. Past Failure

- I do not feel like a failure. (1)
- I have failed more than I should have. (2)
- As I look back, I see a lot of failures. (3)
- 3. I feel I am a total failure as a person. (4)

Q10 4. Loss of Pleasure

- ○ I get as much pleasure as I ever did from the things I enjoy. (1)
- ○ I don't enjoy things as much as I used to. (5)
- ○ I get very little pleasure from the things I used to enjoy. (3)
- ○ I can't get any pleasure from the things I used to enjoy. (6)

Q11 5. Guilty Feelings

- ○ I don't feel particularly guilty. (1)
- ○ I feel guilty over many things I have done or should have done. (2)
- ○ I feel quite guilty most of the time. (5)
- ○ I feel guilty all the time. (4)

Q12 6. Punishment Feelings

- ○ I don't feel I am being punished. (1)
- ○ I feel I may be punished. (2)
- ○ I expect to be punished. (3)
- ○ I feel I am being punished. (4)

Q13 7. Self-Dislike

- ○ I feel the same about myself as ever. (1)
- ○ I have lost confidence in myself. (2)
- ○ I am disappointed in myself. (3)
- ○ I dislike myself. (4)

Q14 8. Self-Criticalness

- ○ I don't criticize or blame myself more than usual. (1)
- ○ I am more critical of myself than I used to be. (5)
- ○ I criticize myself for all of my faults. (3)
- ○ I blame myself for everything bad that happens. (4)

Q15 9. Suicidal Thoughts or Wishes

- ○ I don't have any thoughts of killing myself. (1)
- ○ I have thoughts of killing myself, but I would not carry them out. (2)
- ○ I would like to kill myself. (5)
- ○ I would kill myself if I had the chance. (4)

Q16 10. Crying

- ○ I don't cry any more than I used to. (1)
- ○ I cry more than I used to. (2)
- ○ I cry over every little thing. (3)
- ○ I feel like crying, but I can't. (4)

Q17 11. Agitation

- ○ I am no more restless or wound up than usual. (1)
- ○ I feel more restless or wound up than usual. (2)
- ○ I am so restless or agitated, it's hard to stay still. (3)
- ○ I am so restless or agitated that I have to keep moving or doing something. (4)

Q18 Below is a list of common symptoms of depression. Please read each groups statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Be sure that you do not choose more than one statement for any group.

Q19 12. Loss of Interest

- I have not lost interest in other people or activities. (1)
- I am less interested in other people or things than before. (5)
- I have lost most of my interest in other people or things. (6)
- It's hard to get interested in anything. (2)

Q20 13. Indecisiveness

- I make decisions about as well as ever. (1)
- 1. I find it more difficult to make decisions than usual. (2)
- 2. I have much greater difficulty in making decisions than I used to. (5)
- 3. I have trouble making any decisions. (6)

Q21 14. Worthlessness

- I do not feel I am worthless. (1)
- I don't consider myself as worthwhile and useful as I used to. (2)
- I feel more worthless as compared to others. (5)
- I feel utterly worthless. (4)

Q22 15. Loss of Energy

- ○ I have as much energy as ever. (1)
- ○ I have less energy than I used to have. (2)
- ○ I don't have enough energy to do very much. (3)
- ○ I don't have enough energy to do anything. (4)

Q23 16. Changes in Sleeping Pattern

- ○ I have not experienced any change in my sleeping. (1)
- ○ I sleep somewhat more than usual (8)
- ○ I sleep somewhat less than usual. (3)
- ○ I sleep a lot more than usual. (4)
- ○ I sleep a lot less than usual. (5)
- ○ I sleep most of the day. (6)
- ○ I wake up 1-2 hours early and can't get back to sleep. (7)

Q24 17. Irritability

- ○ I am not more irritable than usual. (1)
- ○ I am more irritable than usual. (2)
- ○ I am much more irritable than usual. (3)
- ○ I am irritable all the time. (4)

Q25 18. Changes in Appetite

- ○ I have not experienced any change in my appetite. (1)
- ○ My appetite is somewhat less than usual. (8)
- ○ My appetite is somewhat greater than usual. (3)
- ○ My appetite is much less than before (4)
- ○ My appetite is much greater than usual. (5)
- ○ I have no appetite at all. (6)
- ○ I crave food all the time. (7)

Q26 19. Concentration Difficulty

- ○ I can concentrate as well as ever. (1)
- ○ I can't concentrate as well as usual. (2)
- ○ It's hard to keep my mind on anything for very long. (3)
- ○ I find I can't concentrate on anything. (5)

Q27 20. Tiredness or Fatigue

- ○ I am no more tired or fatigued than usual. (1)
- ○ I get more tired or fatigued more easily than usual. (2)
- ○ I am too tired or fatigued to do a lot of the things I used to do. (3)
- ○ I am too tired or fatigued to do most of the things I used to do. (4)

Q28 21. Loss of Interest in Sex

- ○ I have not noticed any recent change in my interest in sex. (1)
- ○ I am less interested in sex than I used to be. (2)
- ○ I am much less interested in sex now. (3)
- ○ I have lost interest in sex completely. (4)

Q3 Over the last two weeks, how often have you been bothered by the following problems?

	0 Not at all (1)	1 Several days (2)	2 More than half the days (3)	3 Nearly every day (4)
1. Feeling nervous, anxious, or on edge (1)	○	○	○	○
2. Not being able to stop or control worrying. (2)	○	○	○	○
3. Worrying too much about different things. (3)	○	○	○	○
4. Trouble relaxing. (4)	○	○	○	○
5. Being so restless that it is hard to sit still. (5)	○	○	○	○
6. Becoming easily annoyed or irritable. (6)	○	○	○	○
7. Feeling afraid, as if something awful might happen. (7)	○	○	○	○

	1 Disagree Strongly (1)	2 Disagree a little (6)	3 Neither agree nor disagree (2)	4 Agree a little (3)	5 Agree strongly (4)
1. Discrimination by United Stated authorities (1)	○	○	○	○	○
2. Discrimination in school or at work (14)	○	○	○	○	○
3. Feeling disrespected due to my national background (15)	○	○	○	○	○
4. People making racist remarks towards me (16)	○	○	○	○	○
5. Bothering difficulties communicating in the United States (17)	○	○	○	○	○
6. Difficulties understanding how ordinary life activities in the United States work (shopping, buying tickets, traveling, etc. (18)	○	○	○	○	○

7. Worry about unstable financial situation (19)	○	○	○	○	○
8. Frustration for not being able to support myself financially (20)	○	○	○	○	○
9. Worry about debts (21)	○	○	○	○	○
10. Missing my social life from back home (22)	○	○	○	○	○
11. Longing for my home country (23)	○	○	○	○	○

Q5 For each of the following, please rate the extent to which you agree with each statement, using the scale from 1 to 5 as shown below. Please respond as you really feel, rather than how you think “most people” feel.

	1 Disagree strongly (1)	2 Disagree a little (2)	3 Neither agree nor disagree (3)	4 Agree a little (4)	5 Agree strongly (5)
12. Difficulties understanding documents and forms from authorities (1)	○	○	○	○	○
13. Missing activities that I used to do before coming to the United States (14)	○	○	○	○	○
14. Worry about family members that I am separated from (15)	○	○	○	○	○
15. Feeling sad because I am not reunited with family members (16)	○	○	○	○	○
16. Feeling excluded or isolated in the United States society (17)	○	○	○	○	○
17. Frustration due to loss of status in the United States society (18)	○	○	○	○	○

18. Frustration because I am not able to make use of my competencies in the United States (19)	○	○	○	○	○
19. Distressing conflicts in my family (20)	○	○	○	○	○
20. Feeling disrespected in my family (21)	○	○	○	○	○
21. Feeling unimportant in my family (22)	○	○	○	○	○
22. Family and home country concerns (23)	○	○	○	○	○

APPENDIX K: QUALTRICS QUESTIONNAIRE(SOMALI)

Q2 **CAAFIMAADKA MASKAXDA EE HAWEENKA SOOMAALIYEED EE KU NOOL MAREYKANKA**

(Minnesota State University, Mankato)

OGOLAANSHAHA XOG-URURINTA

IRBNet# 2161978

HORDHAC

Waxaa lagugu martiqaadayaa inaad ka qaybqaadato daraasad ra'yi arurin ah oo ku saabsan sida murugada, walwalka iyo walaacu ay u saameeyaan haweenka Soomaaliyeed. Hadafka daraasaddan ayaa noqon doona in la cabiro dareenka khibrada murugada, walwalka iyo walaaca haweenka Soomaaliyeed ee ku nool Mareykanka. Daraasaddan waxay qayb ka tahay Khadra Hussien (khadra.hussien@mnsu.edu) qalin-jabinteeda takhakhuska barnaamijka dhakhtarnimo oo hoos timaada la taliyaheeda Prof. Jason Kaufman (jason.kaufman@mnsu.edu) ee Waaxda Hogaaminta Waxbarashada ee Jaamacadda Gobolka Minnesota, Mankato.

NIDAAMKA LA RAACAYO
Haddii aad ogolaato inaad ka qaybgasho, waxaad ka jawaabi doontaa ra'yi ururin lagugu waydiinayo su'aalo ku saabsan khibradahaaga murugada, walwalka iyo walaaca. Sahanku wuxuu qaadanayaa 15-20 daqiiqo dhamaystirkiisu. Jawaabahaagu waxay noqon doonaan qarsoodi.

KHATARTA SUURTAGALKA AH EE KA QAYB-QAADASHADA Ka qayb-qaadashada mashruuca waxay xambaarsan tahay khataro aan ka weynayn kuwa nolol maalmeedka. Su'aalaha qaarkood ayaa laga yaabaa inay dareenkaaga kiciyaan. Haddii taasi dhacdo, waad ka boodi kartaa su'aalahaas ama waad ka bixi kartaa gabi ahaanba daraasadda. **FAA'IIDOOYINKA**

SUURTAGALKA AH EE KA QAYB-QAADASHADA Ma jiraan faa'iidooyin la taaban karo oo ku jira ka qaybqaadashada daraasadda.

BAYAANKA QARINTA XOGTA
Dhammaan akhbaaraadka laga aruuriyo mashruucan cilmi-baarista ah waxaa si qarsoodi ah u ilaalin doona Khadra Hussien iyo Prof. Jason Kaufman (La taliyaheeda). Dhammaan macluumaadka waxaa lagu kaydin doonaa goob ammaan ah oo xaddidaysa cidda arki karta xogta jawaabtaada iyo ilaalinta sirtaada. Sidaa darteed, xogta waxaa lagu hayn doonaa adeeg madal sugan ah oo lagu ilaaliyo xogta, iyo siyaasadaha khaaska ah sida Qualtrics iyo Google Forms. Haddii aad rabto macluumaad dheeraad ah oo ku saabsan xafidida xogta iyo khataraha xog ururinta online ka ah, fadlan la xidhiidh Jaamacadda

Gobolka Minnesota, Xarunta Xallinta IT ee Mankato (507-389-6654) oo weydii inaad la hadasho Maareeyaha Amniga Macluumaadka.

NOOCA ISKAA-WAX -UQABSO EE DARAASADDA Go'aankaaga ka qaybqaadashada daraasaddan ma saameyn doonto xiriirka aad hadda ama mustaqbalka la leedahay cilmi-baadhaha ama xiriirka aad la leedahay Jaamacadda Gobolka Minnesota, Mankato, diidmada ka qeybqaadashaduna kuma lug yeelan doonto ganaax ama waayitaan dheefo.. Haddii aad go'aansato inaad ka qaybgasho, xor ayaad u tahay inaad ka baxdo xog aruurinta wakhti kasta adiga oo aan soo celin jawaabahaaga.

XIRIIRKA IYO SU'AALAHA AAD QABTO
Haddii aad wax su'aalo ah ka qabto daraasaddan cilmi-baarista ah, kala xiriir Khadra Hussien 612-423-2542 khadra.hussien@mnsu.edu ama Prof. Jason Kaufman at 952-818-8877 or jason.kaufman@mnsu.edu. Haddii aad wax su'aalo ah ka qabto daraasaddan cilmi-baarista, la xiriir (Baaraha Maamulaha) 952-818-8877 ama Jason.kaufman@mnsu.edu. Haddii aad hayso wax su'aalo ah oo ku saabsan xuquuqda ka qaybgalayaasha iyo walaac cilmi-baarista la xiriira, fadlan kala xiriir Agaasimaha Guddiga Dib-u-eegista Hay'adaha 507-389-1242 ama irb@mnsu.edu. Fiiro gaar ah: Waad codsan kartaa nuqul ka mid ah foomkan ogolaanshaha xogtaada.

BAYAANKA OGOLAANSHAHA
Waan akhriyay warqadan oggolaansha ah waxaana si ikhtiyaarkayga ah aan u oggolaaday inaan ka qaybqaato daraasadda. Waxaan ahay 18 jir ama waan ka weynahay. Doorashadayda "Haa" waxaay cadaynaysaa inaan ogalaaday si ikhtiyaari ah inaan uga qayb qaato daraasadda. Cilmi-baadhayaashu waay ka jawaabeen dhammaan su'aalahaygii ku saabsanaa cilmi-baadhistan.

Q3 Ma ogolaatay inaad ka qayb qaadatid?

- ○ Haa, waan ogolahay (1)
- ○ Maya, ma ogoli (2)

Q34 Fadlan uga jawaab su'aalaha soo socda sida ugu macquulsan ee saxda ah.

Q35 Ma cadaynaysaa inaad dumar tahay?

- ○ Haa. (1)
- ○ Maya. (2)

Q36 Ma cadaynaysaa inaad Soomaali tahay?

- Haa. (1)
- Maya. (2)

Q37 Fadlan noo sheeg da'dda aad hadda jirto:

Waxaan Jiraa.....

	0 10 20 30 40 50 60 70 80 90 100
Fadlan dooro da'dda aad hadda jirto: ()	

Q5 Hoos waxaa ku qoran liiska calaamadaha lagu garto murugada ama niyad-jabka. Fadlan si taxadar leh u akhri qoraalka koox kasta, ka dibna koox kasta ka soo xulo hal qoraal oo si fiican u qeexaya sida aad dareemaysay labadii toddobaad ee la soo dhaafay, oo ay ku jirto maanta. Hubi inaadan kooxna ka dooran wax ka badan hal qoraal.

Q6 1. Murugo

- Ma dareemayo murugo. (1)
- Waxaan dareemaa murugo waqti badan. (2)
- Mar walba waan murugoodaa. (3)
- Si aad ah ayaan u murugaysanahay ama aanana u faraxsanayn oo aanan u adkaysan karin.

Q7 2. Jahwareer

- Kaman niyad jabin mustaqbalkayga. (1)
- Waxaan dareemaa niyad jab badan oo ku saabsan mustaqbalkayga oo aanan horey u daareemi jirin. (2)
- Ma filayo in arrimaha aan doonayo ay ii hirgalaan. (4)
- Waxaan dareemayaa in mustaqbalkaygu rajo la'aan yahay oo uu ka sii dari doono. (6)

Q8 3. Guul-darro Hore

- Ma dareemayo inaan guul-darraystay. (1)
- Wax badan ayaan guul-daraystay. (2)
- Markaan dib u milicsado, waxaan arkaa guul-darrooyin badan. (3)
- Waxaan dareemayaa inaan ahay qof guud ahaan guul-daraystay. (4)

Q9 4. Waayitaanka Farxada

- ○ Farxad badan ayaan ka helaa waxyaabahaan raaxda waligay ka heli jiray. (1)
- ○ Waxyaabo badan oo aan horey u samayn jiray ayaanan hada ku faraxsanayn. (4)
- ○ Wax yar oo farxad ah ayaan ka helaa waxyaabo badan oo aan ku raaxaysan jiray. (3)
- ○ Wax farxad ah kama helo waxyaabihii aan ku raaxaysan jiray. (5)

Q10 5. Dareen Dam-biile.

- ○ Ma dareemayo eed gaar ah. (1)
- ○ Waxaan dareemaa in aan dambiyo ka galay waxyaabo badan oo aan sameeyay ama ay ahayd in aanan la sameeyn. (2)
- ○ Inta badan waxaan dareemaa in aan dambi galay (5)
- ○ Naftayda ayaan eedeeyaa inta badan. (6)

Q11 6. Dareemida Ciqaabta

- ○ Ma dareemayo in la i ciqaabayo. (1)
- ○ Waxaan dareemayaa in la i ciqaabi doono. (2)
- ○ Waxaan filayaa in la ciqaabo. (3)
- ○ Waxaan dareemayaa in la i ciqaabay. (4)

Q12 7. Is-nacayb

- ○ Waxaan dareemayaa sidaan weligay ahaa. (1)
- ○ Kalsoonidii aan qabay ayaa iga luntay. (2)
- ○ Nafteyda waan ka niyad jabay. (3)
- ○ Naftayda waan necbahay. (4)

Q13 8. Is dhaleecayn

- ○ Anigu naftayda ma canaanto, mana eedeeyo in ka badan sida caadiga ah. (1)
- ○ Si ka badan sidii hore ayaan u eedeeyaa naftayda. (4)
- ○ Khalad kasta oo aan sameeyo naftayda ayaan ku eedeeyaa. (5)
- ○ Wax kasta oo xumaan ah oo dhaca ayaan naftayda ku eedeeyaa. (6)

Q14 9. Fikrado ama rabitaan is-dilid

- ○ Wax fikrad ah kama qabo inaan is dilo. (1)
- ○ Waxaan ku fikiray inaan is dilo, laakiin ma samayn. (2)
- ○ Waxaan jeclaan lahaa inaan is dilo. (4)
- ○ Waan is dili lahaa haddaan fursad u heli lahaa. (5)

Q15 10. Oohin

- ○ In ka badan sidii hore uma ooyo. (1)
- ○ In ka badan sidii hore ayaan ooyaa. (2)
- ○ Wax kasta oo yar ayaan u ooyaa. (3)
- ○ Waxaan dareemayaa inaan ooyo, laakiin ma awoodo. (4)

Q16 11. Dareen

○ Walaac owgiis nasasho la'aan ma ahi mana ka xanaaq badni sidii hore. (1)

○ Waxaan dareemaa walaac iyo xanaaq ka badan sidii caadiga ahayd. (4)

○ Aad ayaan u walaacsanahay una xanaaqsanahay oo way igu adagtahay in aan is celiyo.
(5)

○ Aad ayaan u walaacsanahay una xanaaqsanahay oo waxaan rabaa inaa socdo ama wax
sameeyo. (6)

Q17 12. Xiiso Dhac

○ Xiisihii aan u qabay howlaha iyo dadka kale igama lumin. (1)

○ Si ka yar sidii hore ayaan u xiiseeyaa dadka iyo waxyaabaha kale. (2)

○ Inta badan xiisihii aan u qabay dadka iyo waxyaabaha kale way iga lumeen. (4)

○ Way adag tahay inaad wax xiisayso. (5)

Q18 13. Go'aan la'aan

○ Waligay Go'aamo sax ah ayaan qaataa. (1)

○ Waxaa igu adag inaan go'aan gaaro sida caadiga ah. (4)

○ Waxaa igu adag inaan qaato go'aamadii aan qaadan jiray oo kale. (5)

○ Way igu adag tahay inaan go'aan gaaro. (6)

Q19 14. Qiimo la'aan

- ○ Ma dareemayo inaan qiimo leeyahay. (1)
- ○ Uma arko naftayda mid qiimo leh oo waxtar leh sidii aan ahaan jiray. (2)
- ○ Waxa aan dareemaa in aan qiimo lahayn marka la barbardhigo kuwa kale. (4)
- ○ Waxaan dareemayaa wax aan qiimo lahayn. (5)

Q20 15. Fir-fircooni la'aan

- ○ Fir-fircooni badan oo aanan horey u lahayn ayaa igu jirta. (1)
- ○ Fir-fircooni ka yar tii aan horey u lahaa ayaa igu jirta. (2)
- ○ Ma lehi fir-fircooni igu filan oo aan wax badan ku qabto. (4)
- ○ Ma haysto tamar igu filan oo aan wax ku sameeyo. (5)

Q21 16. Isbeddelka Qaabka Hurdada

- ○ Wax isbaddal ah kalama kulmin hurdadayda. (1)
- ○ Waxaan seexdaa wax ka yar sidii caadiga ahayd. (2)
- ○ Waxaan seexdaa wax ka badan sidii caadiga ahayd. (5)
- ○ Waxaan seexdaa wax aad uga yar sidii caadiga ahayd. (6)
- ○ Waxaan seexdaa inta badan maalinta oo dhan. (7)
- ○ Waxaan toosaa 1-2 saacadood ka hor kumana noqon karo hurdadda. (8)

Q22 17. Xanaaq

- ○ Kama xanaaq badni sida caadiga ah. (1)
- ○ Waan ka xanaaq badanahay sida caadiga ah. (2)
- ○ Aad ayaan uga xanaaq badanahay sidii caadiga ahayd. (3)
- ○ Had iyo jeer waan xanaaqaa. (4)

Q23 18. Isbeddel ku yimaada rabitaanka cuntada

- ○ Wax isbeddel ah kuma imaan rabitaanka cuntadayda. (1)
- ○ Rabitaankaygu waa ka yara yar yahay sidii caadiga ahayd. (2)
- ○ Rabitaankaygu waa ka yara weyn yahay sidii caadiga ahayd. (4)
- ○ Rabitaankaygu aad buu uga yar yahay sidii hore. (5)
- ○ Rabitaankaygu aad buu uga weyn yahay sidii caadiga ahayd. (6)
- ○ Haba yaraatee wax niyad ah uma hayo cunto. (7)
- ○ Waxaan doonaa cunto mar walba. (8)

Q24 19. Ku adkaanta in wax xoog la saaro

- ○ Wax xooga waan saari karaa sidii hore oo kale. (1)
- ○ Waxba xooga ma saari kari sidii hore oo kale. (2)
- ○ Way adag tahay inaan wax maskaxda ku hayo wakhti badan. (3)
- ○ Waxaan ogaaday inaanan waxba xoog saari karin. (4)

Q25 20. Daal ama noog

- ○ Kama daal badni sidii hore. (1)
- ○ Si ka fudud sidii hore oo aanan u daali jirin ayaan u daalaa. (2)
- ○ Waxyaabo badan oo aan samayn jiray ayaan hada ka noogaa inaan sameeyo. (4)
- ○ Aad ayaan u daalanahay oo ma samayn karo waxyaalihii aan samayn jiray. (7)

Q26 21. Luminta Xiisaha Galmada

- ○ Madareemin wax is bedel ah oo ku yimi dareenkayga galmada. (1)
- ○ Sidaan horey u xiiseeyn jiray hada uma xiiseeyo. (4)
- ○ Aad ayaan u xiiseeyaa isu taga hadda (3)
- ○ Waxaan lumiyay xiisaha galmada gabi ahaanba. (5)

Q27 Fadlan ka dooro hal jawaab todobadaan su'aalood ee hoos ku qoran:

Q28 Labadii toddobaad ee u dambeeyay, immisa jeer ayey ku dhibeen dhibaatooyinkan soo socda?

	Marna haba yaraatee **0** (1)	**Maalmo badan** **1** (2)	**In ka badan kala badh maalmaha** **2** (3)	**Ku dhawaad maalin kasta** **3** (4)
1. Waxaan dareemaa walwal, walaac, ama inaan qar ka dhacayo. (1)	○	○	○	○
2. Awood la'aan aan walaaca lagu joojin karin ama aan lagu koobi karin. (2)	○	○	○	○
3. Walaac badan oo ku saabsan waxyaabo kala duwan. (3)	○	○	○	○
4. Dhibaato nasasho la'aan ah. (4)	○	○	○	○
5. Nasasho la'aan keenta in fariisigu adkaado. (5)	○	○	○	○
6. Inaad si fudud u xanaaqdid ama u carootid. (6)	○	○	○	○
7. Dareen cabsiyeed oo ah in wax xun ay dhici karaan. (7)	○	○	○	○

Q29 Tilmaamaha: Mid kasta oo ka mid ah su’aalaha soo socda, fadlan qiimee ilaa inta aad ku raacsan tahay, adoo isticmaalaya cabbirka 1 ilaa 5 sida hoos ku cad. Fadlan uga jawaab su’aal walba sida aad dhab ahaantii dareemayso, halkii aad oran lahayd "dadka badankiisu" waxay dareemayaan.

Q30

	Si xoog leh u khilaafsan 1 (1)	**Wax yar Khilaafsan** 2 (4)	**Kumana raacsani kumana khilaafsani** **3** (3)	**Wax yar ayaan ku raacsanahay** **4** (5)	**Si xoog leh ayaan ugu raacsanahay** **5** (6)
1. Midab takoor ka dhex jira maamulka Maraykanka. (1)	○	○	○	○	○
2. Midab kala sooc ayaa ka jira dugsiga ama shaqada. (2)	○	○	○	○	○
3. Waxaan dareemaa xushmo daro meesha aan ka soo jeedo darteed. (3)	○	○	○	○	○
4. Dad ayaa si cunsurinimo ah hadalo tacliiq ah iigu dhaha. (4)	○	○	○	○	○
5. Dhibaatooyin xaga xiriirka ah oo adag ayaa ka jirta Maraykan. (5)	○	○	○	○	○

6. Is fahan xumo la xiiirta sida nolosha caadiga ah ee dadka Maraykanku u shaqayso ayaa jirta (dukaamaysiga, iibsashada tigidhada, socdaalka, iwm.) (7)	○	○	○	○	○

Q31 **Tilmaamaha:** Mid kasta oo ka mid ah su’aalaha soo socda, fadlan qiimee ilaa inta aad ku raacsan tahay, adoo isticmaalaya cabbirka 1 ilaa 5 sida hoos ku cad.
Fadlan uga jawaab su’aal walba sida aad dhab ahaantii dareemayso, halkii aad oran lahayd "dadka badankiisu" waxay dareemayaan.

	Si xoog leh u khilaafsan 1 (1)	**Wax yar Khilaafsan** 2 (4)	**Kumana raacsani kumana khilaafsani** **3** (3)	**Wax yar ayaan ku raacsanahay** **4** (5)	**Si xoog leh ayaan ugu raacsanahay** **5** (6)
7. Ka walwal dhinaca dhaqaalaha ah oo aan xasilloonayn ayaa jirta. (1)	○	○	○	○	○
8. Niyad-jab ah inaanan awoodin in aan naftayda taageero dhaqaale ahaan ayaa jirta. (2)	○	○	○	○	○
9. Waxaan ka walwalaa deymo. (3)	○	○	○	○	○
10. Waxaan u xiisay noloshii aan ku haystey wadankaygii hooyo. (4)	○	○	○	○	○
11. Waan u hiloowey dalkaygii hooyo. (5)	○	○	○	○	○

12. Waay igu adag tahay inaan fahmo warqadaha ama foomamka ka yimaada dowlada. (7)	○	○	○	○	○

Q32 **Tilmaamaha:** Mid kasta oo ka mid ah su'aalaha soo socda, fadlan qiimee ilaa inta aad ku raacsan tahay, adoo isticmaalaya cabbirka 1 ilaa 5 sida hoos ku cad. Fadlan uga

jawaab su’aal walba sida aad dhab ahaantii dareemayso, halkii aad oran lahayd "dadka badankiisu" waxay dareemayaan.

	Si xoog leh u khilaafsan 1 (1)	**Wax yar Khilaafsan** 2 (4)	**Kumana raacsani kumana khilaafsani** **3** (3)	**Wax yar ayaan ku raacsanahay** **4** (5)	**Si xoog leh ayaan ugu raacsanahay** **5** (6)
13. Waan u hilooway waxyaabihii aan qaban jiray intii aanan imaan Maraykan. (1)	○	○	○	○	○
14. Waxan ka walwalaa qayb ka mid ah qoyskagyaoo aan kala maqan nahay. (2)	○	○	○	○	○
15. Waxaan dareemayaa murugo sababtoo ah dib ulama kulmin qaar ka mid ah qoyskagya. (3)	○	○	○	○	○
16. Waxaa ku dareemayaa Maraykanka cidlo iyo ka soocnaan. (4)	○	○	○	○	○

17. Waxaan dareemayaa niyad-jab la la xariirta ku dhex noolaanshaha bulshada ku dhaqan Maraykanka, (5)	○	○	○	○	○
18. Niyad-jab ayaan dareemayaa sababtoo ah awood xirfadeed kuma lihi bulshada Maraykanka dhexdeeda. (7)	○	○	○	○	○

Q33 **Tilmaamaha:** Mid kasta oo ka mid ah su'aalaha soo socda, fadlan qiimee ilaa inta aad ku raacsan tahay, adoo isticmaalaya cabbirka 1 ilaa 5 sida hoos ku cad. Fadlan uga

jawaab su’aal walba sida aad dhab ahaantii dareemayso, halkii aad oran lahayd "dadka badankiisu" waxay dareemayaan.

	Si xoog leh u khilaafsan 1 (1)	**Wax yar Khilaafsan** 2 (4)	**Kumana raacsani kumana khilaafsani** **3** (3)	**Wax yar ayaan ku raacsanahay** **4** (5)	**Si xoog leh ayaan ugu raacsanahay** **5** (6)
19. Khilaaf dhibaato leh ayaa ka dhex jira qoyskayga. (1)	○	○	○	○	○
20. Xushmo daro ayaan kala kulmaa qoyskayga. (2)	○	○	○	○	○
21. Muhiimad kuma dhex lihi reerkayga. (3)	○	○	○	○	○
22. Wal wal qoyska iyo dalkaygii hooyo ah ayaa i haysta. (4)	○	○	○	○	○