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SOMALI IMMIGRANT PERCEPTIONS OF MENTAL HEALTH AND ILLNESS:

AN ETHNONURSING STUDY

A Dissertation

Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for

the degree of Doctor of Philosophy

By

Kimberly M. Wolf

December 2013

SOMALI IMMIGRANT PERCEPTIONS OF MENTAL HEALTH AND ILLNESS:

AN ETHNONURSING STUDY

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Kimberly M. Wolf

Approved August 12, 2013

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ABSTRACT

SOMALI IMMIGRANT PERCEPTIONS OF MENTAL HEALTH AND ILLNESS:

AN ETHNONURSING STUDY

By

Kimberly M. Wolf

December 2013

Dissertation supervised by Rick Zoucha, DNSc, APRN-BC, CTN

      The purpose of this qualitative ethnonursing research study was to explore, discover, and understand the mental health meanings, beliefs, and practices from the perspective of immigrant Somalis living in the United States. Leininger's Culture Care Diversity and Universality Theory, ethnonursing method, and ethnonursing enablers were utilized as organizing frameworks for studying the domain of inquiry. Interviews were conducted with 21 general informants and 9 key informants, all of whom were Somali immigrants living in Minnesota. Utilizing the ethnonursing data analysis enabler, analysis of the interviews revealed 21 categories and 9 patterns from which two main themes emerged. The themes were (a) significant influences of religion on health and care and (b) tribe connectedness, cultural history, and khat usage are significant in health care access and treatment. These findings also detailed what Somali immigrants may value,

need and expect from health care professionals. Implications and recommendations for

practice, education, and research are described.

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DEDICATION

This dissertation is dedicated to my children, David, Dustin, Katelin, and Kailee, who supported me throughout the challenging five years of my doctoral education. Not only did they support and encourage me, they cooked, cleaned, and supported each other when I was busy with work and my studies. Although others may have commented that I was educated enough after my Master's degree, my children never once suggested such. They are my inspiration and the true loves of my life.

I also dedicate this dissertation to my parents who, although they may have not understood why I was working so hard to obtain the higher degree, expressed pride in my accomplishments and encouraged me to accomplish all my educational goals. They have always been there when I have needed them, and I appreciate their support and encouragement.

Finally, this dissertation is dedicated to my friends and co-workers who have shown their support and encouragement throughout my educational journey. I could not have made it without the help of others.

In loving memory of my grandfather, William Schardein, who always said that girls can do anything boys can do. I believed him enough to work hard at everything I did so I could prove he was right in this declaration. He was a wise man that told me from the beginning of my life that I would accomplish great things. He was so happy and proud when I was the first person in my family to earn a Bachelor's degree, and then a Master's degree. I thank him for believing me, expressing pride in me, and encouraging me to take on the world. I'm sure he is smiling in heaven as he watches me earn this doctoral degree.

ACKNOWLEDGEMENT

I want to acknowledge Dr. Rick Zoucha, my dissertation chair, for all of his support and guidance on this study. He was a calm, quiet guide on my educational journey. He allowed me independence when needed so I could explore and appreciate thinking through things on my own first and trusting my own knowledge, and combined this with just the right touch of guidance and direction so I would maintain my appreciation for the input and knowledge of others.

I also want to acknowledge the other members of my dissertation committee, Dr. Marilyn McFarland and Dr. Khlood Salman, for their support and encouragement. I appreciate the knowledge and perspectives that each of my committee members has given me in my educational journey.

Additionally, I would like to thank my gatekeepers and informants for sharing their time and knowledge with me. Their willingness to share not only allowed this study and its findings to unfold, it changed my life.

Finally, I would like to express appreciation to the International Society of Psychiatric Mental Health Nurses (ISPN) for awarding me a research grant that contributed to the financial expenses of this study.

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CHAPTER I

INTRODUCTION

Introduction

According to Scuglik, Alarcón, Lapeyre, Williams, and Logan (2007), the mental

health needs of immigrants in the United States are a crucial aspect of today's health care

arena. They assert that even if the acculturation process follows a conventional course,

the outcome is complicated by the impact of pre-migration losses and other traumatic

events. Adapting to the host society involves adapting to differences in weather, religion,

language, clothing, legal principles, and financial pressures, all of which provide for

enormous mental health implications (Scuglik et al., 2007). Knowledge of immigrants'

mental health care beliefs and practices is needed to assist caregivers with understanding

the population and in providing mental health care that is culturally congruent.

An extensive review of the literature identified a gap in the research on the subject

of Somali immigrants' perception of mental health and illness. More studies are needed

to expand nursing knowledge of Somali mental health beliefs and practices to ensure

caregivers are providing culturally congruent mental health care to Somali immigrants.

After the extensive review, it appeared that this research study would be the first

qualitative ethnonursing study designed to discover the mental health meanings, beliefs

and practices from the perspective of immigrant Somalis living in the United States. The

results from this study contributed to a greater understanding of the Somali culture, their

perceptions of mental health and illness, and what role nursing should play in caring for

the mental health of the Somali people.

Domain of Inquiry

A domain of inquiry, as defined by Leininger and McFarland (2002), is "a succinct tailor-made statement focused directly and specifically on culture care and health phenomenon" (p. 92). The domain of inquiry (DOI) for this transcultural ethnonursing study is the mental health care meanings, beliefs and practices of Somali immigrants within the context of an urban Minnesota city which has a large number of Somali immigrants. This domain of inquiry is important because of the large numbers of Somali immigrants (Burke, 2005) and the large number of Somali immigrants seeking mental health care in this area. Nurses and other mental health caregivers must understand Somali immigrant mental health meanings, beliefs and practices in order to provide care that is meaningful and congruent with his or her beliefs within the Somali cultural context.

Purpose and Goal

The purpose of this qualitative ethnonursing research study was to explore, discover, and understand the mental health meanings, beliefs, and practices from the perspective of immigrant Somalis living in the United States. The researcher asserts that mental health care meanings, beliefs, and practices for Somali immigrants are influenced by shared cultural values, beliefs and practices. The study identified generic (folk) and professional mental health care practices that promote mental health for Somali immigrants. The study also contributed to a greater understanding of the Somali culture and the peoples' perceptions of mental health and illness. The goal of this study was to assist caregivers to plan and implement nursing decisions and actions that promote culturally congruent mental health care for Somali immigrants.

Rationale

Thirty-five percent of all Somali primary refugees entering into the United States in 2000 settled in Minnesota, and many more then migrated to the state from other areas of primary settlement, resulting in the Somali population estimates for Minnesota ranging from 15,000 to 40,000 (Burke, 2005). Some Somali professionals in the community estimate that the numbers are now much higher, ranging from 70,000 to 100,000 (Associated Press, 2010). Also, according to Scuglik et al., (2007), mental health issues are rarely acknowledged by Somalis and their families, creating a barrier that prevents them from seeking professional care. A recent report on Somali refugees in Minnesota concluded that they are among the least served by Minnesota's health and social service systems (Pavlish, Noor, & Brandt, 2010). One of the three main reasons identified was the fact that the group did not have health insurance and challenging payment systems often discourage immigrants from seeking health care. Another reason identified is that Minnesota is one of the least culturally diverse states in the country with people of color representing only 13% of the state's population compared to 32% nationally. The third main reason is that health care professionals whose backgrounds often differ from most of their immigrant patients are frequently unaware of communication barriers that make comprehension and adherence to healthcare difficult for immigrant groups (Pavlish et al., 2010).

As the United States becomes increasingly diverse, psychiatric nurses and other mental health caregivers are challenged to expand their knowledge of the various racial and ethnic groups and develop the skills necessary to care for each patient competently with cultural congruence. According to Leininger and McFarland (2006), culturally congruent care "refers to culturally based care knowledge, acts, and decisions used in

sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways of clients for their health and wellbeing, or to prevent illness, disabilities, or death" (p. 15). With the growing population of Somali immigrants in Minnesota, research on Somali mental health beliefs became increasingly essential, and unquestionably necessary for psychiatric nurses and mental health caregivers to provide appropriate, competent and culturally congruent care.

Research Questions

This research study's Domain of Inquiry was investigated through guided discussions with informants designed to answer the study's research questions. The research questions that guided the study were: 1) What are the care beliefs and experiences of mental health for Somali immigrants living in the US? 2) What are the care beliefs and experiences of mental illness for Somali immigrants living in the US? 3) What are the nursing actions and decisions to promote mental health for Somali immigrants in the US? 4) What are the nursing actions and decisions in caring for mentally ill Somali immigrants in the US?

Significance for Nursing

After working as an advanced practice nurse on an inpatient psychiatric unit in a large Minnesota city, the researcher became concerned about the patient outcomes and whether or not the mental health care provided to Somali immigrants with mental illness was appropriate, beneficial and culturally congruent. From the researcher's anecdotal perspective, the number of Somali patients admitted to the psychiatric units of the hospital was quite high, and the number of readmissions was also noteworthy. The researcher observed the striking cultural differences that existed between the professional

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caregivers and the Somali immigrant patients. The researcher began to question whether the professional mental health care practices in the hospital and in the community were adequate and appropriate for the Somali immigrants. The researcher wondered about the generic/folk care meanings, beliefs and practices of the Somali people outside of the hospital environment. After reviewing the literature, it became quite clear that research was needed in order to answer the researcher's questions.

According to Leininger and McFarland (2002), culture care values, beliefs, and practices influence the mental health and wellbeing of people from all ethnic groups. The cultural elements of mental health care for each ethnic group need to be identified in order to develop culturally congruent mental health care interventions. Understanding the cultural influences on mental health perceptions and practices is thus essential to ensuring healthy patient outcomes. Research focused on Somali immigrants' mental health care meanings, beliefs and practices, and their perceptions of mental health and illness, is limited. Research specific to Somali immigrant mental health care is needed in order to learn about the specific cultural influences, as well as the particular mental health needs of this group of people.

Mental health has many components and involves a variety of healthcare disciplines. The discipline of nursing is in a position to take the lead in discovering cultural knowledge and ensuring the delivery of culturally competent care. Mental health transcultural nursing research could potentially increase the interest of professional from other health care disciplines in Somali immigrants' perceptions of mental health and increase their motivation to provide culturally competent care to immigrants from around the world. According to Leininger and McFarland (2006), discovery of cultural care

meanings, beliefs and practices is made possible through the use of the ethnonursing method guided by the culture care theory. This method provides a means for the discipline of nursing to build a knowledge base of specific cultures from which many disciplines can benefit and move the impetus forward to provide each individual seeking mental health care with appropriate, competent and culturally congruent care. The findings from this study will be made available to inform nursing and other disciplines interested in culturally based mental health care outcomes. This study has led to increased understanding and knowledge of Somali immigrant mental health care perceptions, practices and needs.

Research identifying the differences and similarities in mental health and illness perceptions and practices between Somali immigrants and their American caregivers contributes to the knowledge base of transcultural care. With increased knowledge of Somali folk/generic mental health care meanings, beliefs, and practices, sensitivity to cultural universalities and diversities between the Somali and American cultures was enhanced for nurses and other healthcare professionals. Research discovering the Somali folk/generic mental health care practices can be combined with professional care practices to provide culturally appropriate, competent, and congruent mental health care to this group. This will likely increase adherence and improve patient outcomes. Increasing understanding and decreasing discord between caregivers and patients also has the potential to lead to more positive health outcomes.

Research expanding the knowledge of Somali immigrant generic mental health care meanings, beliefs, and practices is also important and relevant for nursing education. Transcultural nursing research, when reported in the nursing literature, disseminates

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cultural care knowledge and discoveries. This transcultural nursing research informs nurse educators about culturally specific mental health care for Somali immigrants in the United States. This study has contributed to nursing educator's ability to positively influence and encourage culturally congruent mental health care for Somali immigrants.

There is a gap in the literature regarding Somali immigrants' perception of mental health and illness, and findings from an ethnonursing research study guided by Leininger's theory of Culture Care Diversity and Universality was used to discover and acknowledge the cultural mental health care patterns and needs in this group of people. The results from this study contributed to a greater understanding of the Somali culture and their perceptions of mental health and illness, increased the understanding of what the role of nursing is in promoting mental health and caring for mentally ill Somali immigrants, as well as provided a knowledge base for other disciplines and nursing educators to use for the promotion of culturally competent mental health care for the Somali population.

Orientational Definitions

The following definitions were used to give direction to this study:

Construct	Definition
Cultural Competence in Mental Health Care	Multidimensional process that aims to achieve culturally congruent mental health care delivery (adapted from cultural competence definition; Jeffreys, 2010).
Culturally Congruent Mental Health Care	Mental health care that fits with the client's cultural values, beliefs, practices, traditions,

	and lifestyle (adapted from culturally congruent definition; Jeffreys, 2010).
Cultural Values	A cultural group's specific values that usually serve as the foundation for their acceptance and use of health resources or a group's participation in community-based intervention programs to promote health and wellness (adapted from community cultural values definition; Andrews & Boyle, 2008).
Emic View	Somali, or insider's cultural knowledge and view of specific phenomena (Leininger & McFarland, 2006).
Etic View	Health professional views and institutional knowledge of phenomena (Leininger & McFarland, 2006).
Generic Mental Health Care	Learned and transmitted Somali traditional, or local folk mental health knowledge and practices to provide assistive, supportive, enabling, facilitative acts for or towards others with evident or anticipated mental health needs in order to improve mental wellbeing (adapted from professional care

	definition; Leininger & McFarland, 2006).
Mental Health	A state of mental well-being that is culturally defined and constituted by Somali immigrants; a state of mental being to maintain and the ability to help individuals or groups to perform their daily role activities in culturally expressed beneficial care and patterned life-ways (adapted from definition of health; Leininger & McFarland, 2006).
Mental Illness	Somali culture bound illness affecting mood, affect, perception, and behavior, and for which the manner in which it is perceived and expressed by a cultural group has a direct effect on how individuals present themselves and, consequently, on how health-care providers interact with them (adapted from Purnell & Paulanka, 2008).
Professional Mental Health Care	Formal and explicit cognitively learned professional mental health care knowledge and practices obtained generally through educational institutions (adapted from

	professional care definition; Leininger & McFarland, 2006).
Somali Immigrant	An individual who self-identifies with the Somali culture and has immigrated to the United States.

Assumptions

The major assumptions for this study were adapted from the assumptions of the Culture

Care Theory. They relate to the purpose and vision of the study and are as follows:

1. The Somali culture has generic and professional care to be discovered and used for

culturally congruent care practices (Leininger and McFarland, 2002).

2. The meanings and experiences of mental health care will become understandable

when viewed within the cultural context of Somali immigrants (Leininger and

McFarland, 2002).

3. Mental health care meanings and experiences within the Somali cultural context will

contribute to nursing knowledge and practice (Leininger and McFarland, 2002).

4. Culturally congruent mental health care practices will assure appropriate, meaningful

and competent care for Somali immigrants (Leininger and McFarland, 2002).

Summary

This study contributed to the discovery of the meanings, beliefs and practices of

mental health care for Somali immigrants. This study is significant for nursing because

the findings can be used to increase understanding and educate caregivers about

providing culturally congruent and competent care to the Somali immigrants. These

findings have the potential to enhance the mental illness treatment plan outcomes and overall mental health and well-being of this population. Nurse educators and caregivers from other disciplines may also use the discoveries from this study to provide culturally congruent care to the Somali population. This study increased the body of transcultural nursing knowledge about Somali immigrants and their perceptions of mental health care and illness.

CHAPTER II

REVIEW OF LITERATURE

Ethnohistory of the Somali Culture

Somalia is a country in Eastern Africa that borders the Gulf of Aden and the Indian Ocean. It is a long, narrow country that wraps around the Horn of Africa. The inland areas are primarily plateaus, although there are some rugged mountains and hills in the north. The northern region is dry, but the southern portion has regular rainfall and can be marshy. Many Somalis are nomadic or semi-nomadic herders; others are fishermen and farmers. Somalia, unlike many of the other African countries, is composed of a principally homogeneous ethnic group that shares a common language, religion and culture and can trace their heritage to a common ancestry (U.S. Department of State, 2011).

According to the U. S. Department of State (2011), early history traces the development of the Somali state to an Arab sultanate. They report that during the 15th and 16th centuries, Portuguese traders landed in Somali territory and ruled several of the coastal towns. The sultan of Oman and Zanzibar took control of these towns and their surrounding territory. Somalia's modern history began in the late 19th century, as a variety of European powers began to trade and establish themselves in the area. Among these powers was the British East India Company. The company desired unrestricted harbor facilities and treaties were signed that allowed the British control over northern Somalia and guaranteed Somali chiefs British protection. The British wanted to secure the trade links to the east, as well as ensure a local source of food and provisions for the coaling station they operated in Aden (U. S. Department of State, 2011).

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The U. S. Department of State (2011) reports that in the first two decades of the 1900s, British rule was challenged by a rebellion led by Mohamed Abdullah (known as the "Mad Mullah" by the British). There was a long series of intermittent battles and truces that ended in 1920 when British warplanes bombed Abdullah's stronghold. Although Abdullah was defeated as much by rival Somali factions as it was by British forces, Abdullah is viewed as a popular hero and stands as a major figure of national identity to many Somali people (U. S. Department of State, 2011).

Italy also obtained commercial advantages in this area from the sultans of Zanzibar, Obbia, Aluula, and their territories were placed under Italy's protection in the late 1800s (U. S. Department of State, 2011). Italy made agreements with the Ethiopians and with the British during this time that marked out the boundaries of Italian Somaliland. The Italian Government assumed administration and gave the territory colonial status. Italian occupation began to slowly move inland (U. S. Department of State, 2011).

After Italy's declaration of war on the United Kingdom in June 1940, Italian troops took over British Somaliland (U. S. Department of State, 2011). But in 1941, British forces fought back against the Italian East African Empire and brought the greater part of Italian Somaliland back under British control. While Somalia was under British administration, there was a transition toward self-government, and local courts and planning committees were established. In 1949, a peace treaty resolution allowed Italian Somaliland to be placed under an international trusteeship system for 10 years, with Italy as the administering authority, which would then be followed by independence for Italian Somaliland. Meanwhile, the rapid progress toward self-government that was being made

in British Somaliland lead to the request that the United Kingdom grant the area independence so that it could be united with Italian Somaliland when it became independent. British Somaliland became independent on June 26, 1960, and five days later it joined Italian Somaliland to form the Somali Republic. Somalia then adopted its first national constitution which provided for a democratic state with a parliamentary form of government based on the European models (U. S. Department of State, 2011).

Under the leadership of Prime Minister Egal from 1967 to 1969, Somalia relinquished its claim to the Somali populated regions of Ethiopia and Kenya to improve its relations with these countries (U. S. Department of State, 2011). However, Ethiopia had been a traditional enemy of Somalia since the 16th century, and so this move toward reconciliation with Ethiopia made many Somalis very angry. There is the view that this reconciliation effort is the leading factor that provoked the bloodless coup in 1969. The coup then led to the induction of Major General Mohamed Siad Barre as president which brought an end to the Somali constitutional democracy. Barre pursued scientific socialism that reflected an ideological and economic dependence on the Soviet Union. He controlled information, instituted a national security service, and used military force and terror to seize rich farmlands. In 1974, Somalia and the Soviet Union signed a treaty of friendship and cooperation (U. S. Department of State, 2011).

In 1977 however, Barre expelled all Soviet advisers and ended the friendship agreement with the Soviet Union (U. S. Department of State, 2011). Barre took this action because the Soviet Union had assisted Ethiopians in the defeat of the Somali National Army and the Western Somali Liberation Front (WSLF). These Somali forces had attempted to regain the Ogaden region of Ethiopia after the overthrow of the

Ethiopian Emperor in 1975. Somali forces had to retreat back into Somalia, but the WSLF continued to carry out sporadic guerrilla activity in the Ogaden. After abandoning the Socialist ideology and wanting to find another strong external alliance, Somalia turned to the West for international support, military equipment, and economic aid. In 1978, the United States reopened the U.S. Agency for International Development mission in Somalia and a couple years later an agreement was signed that gave U.S. forces access to military facilities in northwestern Somalia. The United States considered Somalia a partner in defense in the Cold War from 1982 to 1988, and Somali officers were trained in U.S. military schools (U.S. Department of State, 2011).

According to the U. S. Department of State (2011), the Barre regime used violence to suppress opposition movements. The regime used the military and elite security forces to suppress any hints of rebellion. By the 1980s, an all-out civil war had developed in Somalia. Opposition groups had formed at the end of the Ogaden war, including a group of dissatisfied army officers known as the Somali Salvation Democratic Front (SSDF). In 1981, the Somali National Movement (SNM) was formed with the stated goal of overthrowing of the Barre regime. Economic crisis had occurred and caused further hardship as Siad Barre drained the national treasury. Opposition to Barre's government became fully operational in the northern regions and began to spread to the central and southern regions. Hundreds of thousands of Somalis fled their homes, and had to take refuge in neighboring Ethiopia, Djibouti, and Kenya. The Somali army collapsed and members rejoined their respective clan militias. Barre's territorial control was reduced to the immediate areas surrounding the capital city of Mogadishu, which resulted in the withdrawal of external assistance and support, including that from the

United States. The Somali state was in the final stages of a complete collapse by the end of 1990 (U.S. Department of State, 2011).

According to Brons (2001), Somalia has been without a state, or single government entity, since 1991. The Somali state collapsed when, at the climax of the civil war in the beginning of 1991, President Siyad Barre fled the capital city Mogadishu because the numerous clan-affiliated groups which had joined forces to take control of most of the country had finally won the battle for Mogadishu (Brons, 2001). However, these victorious groups were not able to unite in forming a new government, and as a result, the former Somali state was controlled by different military factions and fell apart politically into various territorial units (Brons, 2001). There are a number of different political entities on Somali territory, and because different military group leaders exercise politico-military dominance over particular territories, the boundaries remain unsettled, and sporadic fighting and political maneuvering continue up to this present time (Brons, 2001).

Numerous Somalis have been forced to leave Somalia, and countless others have chosen to flee the country due to civil strife and continued unrest (Brons, 2001). Many of Somali's refugees immigrated to the United States with the assistance of charity organizations. The largest collection of Somali refugees in the United States currently reside in Minnesota (Pavlish et al., 2010). The 2010 (United States Census Bureau, 2011) American Community Survey indicates that Minnesota is home to more people with Somali ancestry than any other state. It reports that about 25,000 of the 85,700 Somalis in the United States live in Minnesota. However, according to Hashi Shafi, executive director of the Somali Action Alliance, this estimate is low (Associated Press,

2010). He estimates the Somali Minnesota population to be about 70,000. Also, the

Minneapolis Public Schools report 1,345 of the district's students during the 2008-2009

school years speak Somali at home, and these numbers have continued to grow

(Associated Press, 2010). Despite the need, very few studies to date have been conducted

on African immigrant groups (Pavlish et al., 2010).

    Foreign relations. According to the U. S. Department of State (2011),

subsequent to the collapse of the Barre regime, the foreign policy of the various entities

in Somalia has centered on gaining international recognition, winning international

support for national reconciliation, and obtaining international economic assistance.

Although the United States never formally severed diplomatic relations with Somalia, the

U.S. Embassy in Somalia has been closed since the collapse of the Siad Barre

government in 1991. The United States maintains regular dialogue with the key

stakeholders in Somalia through the U.S. Embassy in Nairobi, Kenya (U.S. Department

of State, 2011).

    Economics factors. According to the Central Intelligence Agency (2011), despite

the lack of an effective national government, Somalia has been able to maintain a fairly

healthy informal economy. This has been based largely on livestock, remittance/money

transfer companies, and telecommunication companies. Agriculture is viewed as the most

important division as livestock normally accounts for about 40 percent of the Gross

Domestic Product (GDP) and more than 50 percent of the export earnings. A large

portion of the population in Somalia is made up of nomads and semi-pastoralists that

depend on livestock for their livelihood. Unfortunately, Somalia's small industrial

division, based largely on the processing of agricultural products, has been looted and the

machinery sold as scrap metal. Somalia's service division has grown however, and telecommunication companies provide wireless services in most major cities with the lowest international call rates on the continent. There is no formal banking division in Somalia, so money transfer/remittance services have sprouted throughout the country and handle up to $1.6 billion in remittances annually. Hotels are in operation and are supported by private-security militias. Due to continued armed attacks on humanitarian aid workers, the World Food Programme suspended its operations in Somalia (Central Intelligence Agency, 2011).

Religious factors. According to the U. S. Department of State (2011), 99.9 percent of the people living in Somalia identify themselves as Muslim. The Central Intelligence Agency (2011) also lists Islam as the religion of Somalia, and reports that Islam is a monotheistic Abrahamic faith originating with the teachings of Muhammad in the 7th century. Muslims believe that Muhammad is the final of all religious prophets and that the Qur'an (the Islamic scripture) was revealed to him by God. Obedience to God is the primary theme of Islam. To live an Islamic life is to follow the five tenets of Islam, which are the testimony of faith (*shahada*), daily prayer (*salah*), giving alms (*zakah*), fasting during Ramadan (*sawm*), and the pilgrimage to Mecca (*hajj*) (Central Intelligence Agency). According to the U. S. Department of State, there is also a small, low-profile Christian community and small numbers of followers of other religions.

Political factors. The Central Intelligence Agency (2011) reports that there have been 1.1 million Somali refugees and internally displaced Somali persons since 1988 due to the civil war and clan-based competition for resources. The agency also reports that in

2007, Ethiopian forces invaded Somalia and forced Islamic courts out of Mogadishu. Currently secessionists are providing port facilities to landlocked Ethiopia and have established commercial ties with other regional states as well. The secessionists are seeking international support in their aspirations and overlapping border disputes. Kenya works hard to prevent the clan and militia fighting that is occurring in Somalia from spreading south across the border (Central Intelligence Agency, 2011).

The U.S. Department of State (2011) reports that Somalia has a transitional government, known as the Transitional Federal Government (TFG). The State Department also reports that Somalia does not have a current functioning constitution in force. However, a Transitional Federal Charter was established in February of 2004 and is expected to serve as the basis for a future constitution in Somalia (U. S. Department of State, 2011).

Technological factors. The U.S. Department of State (2011) reports that cellular phone service is readily available throughout Somalia, but the landline communication systems have been destroyed and are not operational. Telecommunication companies continue to provide wireless services in most of the major cities with the lowest international call rates on the continent (Central Intelligence Agency, 2011). The U. S. Department of State also indicates that Somalia is linked to the outside world via ship-to-shore communications (INMARSAT). There are also available links to overseas satellite operators through private telecommunications operators (including cellular telephone systems) in the major cities. There are radio broadcasting stations in operation with programs in Somali and some other languages in Mogadishu, Hargeisa, and Galkacyo, as

well as two television broadcast stations in Mogadishu and one in Hargeisa (U. S. Department of State, 2011).

Educational factors. The Central Intelligence Agency (2011) reports that total estimated population literacy rate (percent of the population over the age of 15 that can read and write) is 37.8 percent. For men the percentage is a little higher at 49.7 percent and for women it is lower at 25.8 percent. The agency reports that the school life expectancy (primary to tertiary education) is estimated to be 3 years for the total population and for men, but only 2 years for women. The U. S. Department of State (2011) reports Somali is the official language and the language of instruction in schools, but indicates that Arabic, Italian, and English are also spoken and used frequently.

Kinship and social factors. According to Brons (2001), in the pre-civil war period, intermarriage between different clans was uncommon. This author also reports that marriage established relationships between lineages laid the basis for general collaboration, while providing the medium to secure preferences in employment and trade opportunities. This practice encourages an extensive range of affinal ties. Frequently, the foundation of lineage coalition is the husband's lineage in relation to his wife's father's lineage. Married Somali women maintain contact with their biological families throughout their lives. This matrilineal connection provides social and economic ties of support as needed, although in the political domain, patrilineal descent remains the influential factor. Even so, linkages to different clans are important political catalysts for peace making. Polygamy is not uncommon and is a practice that increases the flexibility of the clan system. Furthermore, children of a divorced couple remain members of the broader collection of relatives. Although marriage between different clan members is no

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longer common because of the extreme politics of clan affiliation and the rise of clan related violence, women do still play a role in narrowing clan differences (Brons, 2001).

Cultural values and lifeways. According to Brons (2001), there are three ways in which Somali people identify themselves. One of the ways is whether they are a nomad or a sedentary. A common interpretation of the name Somali, derived from the name *Soomaali*, originates in the nomadic pastoral tradition. The words *soo* and *maal* mean 'go milk' with an implicit reference to the camel. Religious identity is another way the Somali people identify themselves, especially related to the unifying and dividing aspects of the Islamic religion. The Muslim Somali religion is unifying against the Christian religion, but there are also differences within the religion that cause discord among the Somali people. The third characteristic recognized as important to the Somali people is clan identity. As a stateless nomadic society, clan identity has a particularly important political connotation. It has become increasingly political and often violently expressed. This is especially true as clans compete for limited resources and power (Brons, 2001).

Synthesis of the Literature

The literature review will review the current available studies regarding the Somali population and some work that has been done with Somali people, along with literature affirming the challenges of working with immigrants. This review exposed the gaps in the literature and supported the need for the study.

Somali refugee health concerns. It is generally accepted that refugees have a set of culturally specific health care needs that go beyond the needs of a healthcare facility's typical patient presentation (Warfa et al., 2006). Warfa et al. (2006) conducted a qualitative research study with the purpose of exploring the meaning of geographical

mobility for Somali professionals and refugees living in London, UK. The researchers specifically examined how geographic mobility might relate to mental health status and health service use. The study accomplished its purpose by utilizing two discussion groups with 13 Somali professionals and four groups with 21 lay Somalis in East and South London, UK. A systematic manual text analysis of six discussion groups was completed using the framework analysis method. The authors report that "migration" is associated with poor health outcomes for certain marginalized and socially disadvantaged populations. The authors reviewed reasons why residential mobility in the 'host' country may be associated with poor mental health for refugee populations, and discuss the relationship between residential mobility, poor health, and health service use. The links between residential instability, mental health, and health service was discovered to be as important to the lay respondents, as it was to the professional group (Warfa, et al., 2006).

Scuglik, Alarcón, Lapeyre, Williams, and Logan (2007) reported that Somalis rarely acknowledge psychiatric problems and common traditional treatments for psychiatric symptoms have become ineffective in the new context of their lives. These authors conducted a study with the aim to identify and explore cultural dynamics influencing the psychiatric care of immigrant Somalis in the USA. The researchers reviewed demographic data from the Minnesota Departments of Human Services, interviewed health professionals, and also explored community perceptions of medical and psychiatric needs, cultural characteristics, barriers to care, and potential solutions. They accomplished their goal partially through the use of an informal survey of 37 members of the Mayo Clinic Department of Psychiatry and Psychology to determine caregiver perceptions of care of Somali patients. The survey identified

language barriers (74%), and cultural misperceptions (68%) as the most frequent obstacles to providing mental health care. Recommendations from this study included alternative health care approaches utilizing family values, `bargaining,' and educational approaches to acculturation (Scuglik, et al., 2007).

Community efforts. Some communities are taking measures to improve community mental health organizations that Somali immigrants frequent. Pyke, Morris, Rabin, and Sabriye (2001) describe the action taken by a community mental health organization in Toronto, Canada with staff who are predominately white and unilingual (not the same language as the Somali immigrants) to be more accessible and responsive to the Somali immigrant community. Board, staff, and consumer contributions provided input into the development of non-discriminatory policies in the organization through a community action plan. These authors identified that almost all Somalis are Muslim, which the authors assert plays a role in their daily lives and must be considered when providing health care to this population. The developed community action plan recognizes that the immigrant's concepts of health and illness are based on a combination of Muslim and traditional Somali beliefs. These beliefs include the belief that illness is the will of Allah (God in the Arabic language), and people are expected to bear it; as well as the belief that mental illness is caused by spirits or "jin" and is highly stigmatized (Pyke et al., 2001).

Mölsä, Hjelde, and Tiilikainen (2010) conducted two focus groups with Somali seniors and two individual interviews with Islamic healers who had been identified as being the most popular religious healers by the seniors in metropolitan Helsinki to gather information about the definition of mental illness in a Somali cultural context. They also

collected information regarding traditional and religious ways of treating mental distress, differences between understanding and treatment of mental illness in Somalia and in Finland, and experiences of health services in Finland, including mental health services. The group interviews were conducted by Mulki Mölsä in their native Somali language in gender-separated sessions with 20 women and 7 men. The authors reported that because both group interviews worked well, which they believed secured the validity of the results and allowed for data saturation; the groups met only once, but for up to five hours at a time (Mölsä et al., 2010).

All informants in the project conducted by Mölsä et al. (2010) belonged to the small group of Somali seniors in Finland, who had lived through the colonization and independence of Somalia, dictatorship, the civil war and exile. It was recognized that they were not representative of the Somali population in Finland, but of their own age group. It was understood that younger Somalis raised in Finland would likely have different conceptions of mental health. Information from the focus groups indicated that conditions conceptualized by the Finnish biomedical system as mental disorders were seen by most Somalis as spiritual and/or social problems. The authors of this article indicate that Somalis face new sources of suffering with immigration and have developed new ways of interpreting these. Therefore, traditional conceptions of mental distress both persist and change. The authors assert that Islamic understandings of healing, including notions of "jin" spirits and treatment, continue to be important (Mölsä, et al., 2010).

Somali mental health studies. Only a few research studies were found in the literature that focus on Somali immigrants' mental health. Ellis et al. (2010) conducted a mixed-method research study that employed a community participatory approach to

examine the utility of the Gateway Provider Model (GPM) in understanding service utilization and pathways for Somali refugee adolescents living in the Northeastern United States. One hundred forty four adolescent refugees and their caregivers were enrolled through purposive sampling for the quantitative portion of the study. A subset of fourteen adolescent subjects from the full sample also participated in in-depth interviews. The GPM was found to provide a helpful model for understanding refugee youth access to services. The findings in this study demonstrated a large gap between the need for, and access to, services for Somali adolescent refugees. Adolescents reported believing that therapy was stigmatizing and outside of the traditional culturally accepted means of seeking help. Although the current mental health service system was rarely utilized and was not valued by Somalis, other sources of help and pathways to care including family, religious leaders, friends and schools were identified as preferred providers of assistance (Ellis, et al., 2010).

Whittaker, Hardy, Lewis, and Buchan (2005) conducted a cross-sectional study with the aims of exploring individual and collective understandings of psychological well-being among young Somali asylum-seeker or refugee women in Northern England. They gathered data for their study through three group and five individual semi-structured interviews. The five participants of this study were recruited through convenience sampling. The researcher also interviewed four adult informants including Somali mental health workers to provide informal triangulation of the findings and to enhance cultural sensitivity by learning about the Somali culture. The themes identified by these researchers after utilizing Interpretative Phenomenological Analysis were resilience and protection; identity and beliefs; and concealment, distancing and secrets,

which reflected acculturation, Islamic and Somali cultures. Spirit possession was also explored in this study in relation to culture and religion, mental health, protection and treatment. The study found that Somali women 'get on', cope with life and value support from family, services and religion. However, the stress of conflicting and changing cultural and religious positions, as well as their desire to conceal distress, create barriers to accessing support. The findings illustrated a paradox of how Somali women value both support and concealment, and fear disclosures (Whittaker, et al., 2005).

Simich, Maiter, and Ochocka (2009) conducted a participatory action research project with a focus on mental health with five different ethnic groups (Mandarin-speaking Chinese, Polish, Punjabi Sikh, Somali and Spanish-speaking Latin American) in Ontario, Canada. Data was collected through twenty-one focus groups as part of a large, multidisciplinary venture. By utilizing snowball sampling, 185 participants (two focus groups in each ethno-linguistic community in each study site) were included in the study. The purpose of the focus groups was to understand culturally diverse conceptualizations of mental health problems, to understand perceptions of mental health interventions and to obtain community perspectives about necessary services. Study findings indicated that while immigrants perceive themselves to be in a psychologically stressful, transitional state and they must work to actively cope with cultural tensions and respond to mental health challenges that are stressful, there is also the potential to help individuals adapt by producing a positive synthesis of ideas about mental health in new social and cultural contexts. The researchers report that their study should contribute to a shift from problem identification using a biomedical model of mental illness to a more psychosocial and

ecological approach that reveals the potential for resolving some mental health problems experienced in immigrant communities (Simich, et al., 2009).

Kroll, Ysuf, and Fujiwara (2010) observed an unusually high number of young Somali men presenting as psychotic to a busy inner-city community clinic in Minnesota. They conducted a research study between 2001 and 2009 to investigate the major patterns of psychiatric disorders in the Somali outpatient population (N = 600) to compare to a cohort of non-Somali patients (N = 3,009) seen at the same clinic during 2007 to 2009. Somali and non-Somali patients were diagnosed according to the DSM-IV-R criteria, and main outcome measures (diagnoses, age cohort, and sex) were analyzed by Chi-square tests. They found that patterns of illness and adjustment varied significantly depending on age and gender. They reported that this reflected the relevance of age and gender at the time of trauma on the various traumatic and loss experiences, as well as the cultural and religious shaping of subsequent adjustment and symptom expression. The study confirmed that almost half of the Somali male patients were under the age of 30, and 80 percent of them presented with psychoses. This was compared to a rate of 13.7 percent in the same age non-Somali male control group. They found that older men and the majority of Somali female patients presented with predominantly depressive and PTSD symptomatology (Kroll, et al., 2010).

Kroll, et al. (2010) determined that the study results indicated that more research in Somali mental health was needed. They determined a study of community prevalence of mental illness among different age and gender cohorts was desirable, since their study was not a study of prevalence of mental illness in the Somali community. They also contended that further research should be undergone to look into the likely causative and

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contributory risk factors to explain the development of psychoses among young Somali men. They concluded that war trauma experienced in childhood, early malnutrition from famines, head trauma, and excess khat (shrub from East Africa with a stimulant effect that is smoked or chewed) use in male adolescents provided a partial explanation for the large number of young Somali men seen in the clinic for psychosis (Kroll, et al., 2010).

Somali mental health care suggestions. Two Somali patient case studies that offered insights and suggestions into caring for a Somali patient with mentally illness were found during the literature review. Boynton, Bentley, Jackson, and Gibbs (2010) present a case study of a 55-year-old Somali refugee suffering from depression and posttraumatic stress disorder to provide for an opportunity to offer suggestions through the case study of ways in which clinicians may respond to, and work with, Somali patients in order to promote their well-being in a culturally competent manner. This refugee patient of interest had lived in the United States for 17 years after his wife and he fled Somalia with two of their children, ages 8 and 10. They were forced to leave on short notice and had to leave their two eldest children, ages 15 and 18, and a large extended family behind. After leaving Somalia, he spent time in a densely populated Kenyan refugee camp. While at the refugee camp, his family had rare access to medical care and experienced violence similar to what he had left behind in Somalia. Since arriving in the United States, he has experienced poverty, unemployment, housing problems, and difficulty adjusting to urban American life (Boynton, et al., 2010).

Boynton, et al. (2010) report that there is a cultural unfamiliarity with the concept of mood disorders in the Somali explanatory model of mental illness. For Somalis, the concept of mental health has traditionally been divided into categories of "sanity" and

"insanity." People who demonstrate psychosis and are either violent or have behaviors that cannot be controlled are labeled "insane." The Somali gentleman in the case study feared seeing a psychiatrist and being labeled "insane." Families in Somalia usually care for their mentally ill family members in their home, sometimes having to chain them for safety. Taking them to a psychiatric ward is a last resort due to the stigma that is associated with mental illness. Mood disorders are treated with family support, religiously based interventions, and indigenous herbal remedies. These authors suggest that clinicians in the United States who are treating Somalis with diagnosed or suspected mood disorders can improve care by recognizing the lack of familiarity in traditional Somali culture with the idea of seeking professional care for emotional difficulties, incorporating Islamic customs in treatment planning, spending extra time with patients to help build a therapeutic relationship, and appreciating the multiple layers of stigma attached to mental illness from the perspective of Somali culture (Boynton, et al., 2010).

Groen (2009) presents similar suggestions when treating mentally ill Somali patients. He proposes that although there are several ways to produce a cultural formulation that facilitates a culturally sensitive diagnosis and treatment for refugees in mental health care, it is essential to gain trust and 'recognize' the patient. He uses a case study presentation to illustrate a cultural interview process in which cultural references of the health care provider and the patient are exchanged. The case is a Somali immigrant to the Netherlands, whose passivity and inactivity in the therapeutic relationship initially causes difficulty for his psychiatrist. Gaining his trust and recognizing his cultural roots as a member of a Somali cultural group exposed his motives, concepts and attitude which suggested the importance of cultural identity as a way to explore the meanings of the

illness and the interrelationship between the patient and health care provider. The author suggests that the cultural identity of a patient is a basis on which meanings can be discovered and exchanged and give the starting point for effective treatment (Groen, 2009).

Mohamed and Loewenthal (2009) offer suggestions in conducting ethical research with the Somali immigrant population. They were planning a qualitative participatory research study with the Somali immigrant population in the UK, and discuss the ethical concerns that have come to light in their planning. They note several barriers to mental health care for Somalis including a different understanding of mental health disorders, mistrust of providers due to past traumas and stigma in the culture surrounding mental health and its association with violence. Due to the likelihood that the Somali immigrants will want to put their loved ones first, the authors warn that researchers should make sure that the research will benefit the Somali population. They also warn about the need to have informed consent that is really informed (Mohamed & Loewenthal, 2009).

Women's healthcare. Guerin, Elmi, and Guerin (2006) discuss how Somali immigrant women at risk for mental illness found ways to cope with the challenges they faced. In a small city in New Zealand that had no specialist services for refugee mental health, a group of Somali refugee women held wedding parties which were seen as contributing positively to their mental health and feelings of well-being. Using an ethnographic approach, these authors discovered through surveys, more than 900 interviews, focus groups and participant observation the change in wedding parties over time and how this was associated with the well-being of a Somali community. They

suggest that mental health professionals can learn from this and contribute to facilitating and encouraging these types of activities and change processes (Guerin, et al., 2006).

Pavlish, Noor, and Brandt (2010) utilized a socio-ecological perspective and a social action research design to conduct six community-based focus groups with 57 Somali women who re-located to Minnesota as refugees after escaping violence in their war-torn country. They also interviewed 11 key informants, including Somali healthcare professionals. After inductively coding, sorting and reducing data into categories, they analyzed each category for specific patterns. They found that Somali women's health beliefs are related closely to situational factors and are in contrast with the biological model that drives Western medicine. These differing health beliefs resulted in differing expectations regarding treatment and healthcare interactions. Experiencing unmet expectations and needs, the Somali women and their healthcare providers reported multiple frustrations which often diminished quality of health care. The women expressed that they had silent worries about mental health and reproductive decision making. These researchers indicate that to provide high quality, transcultural healthcare providers must encourage patients to voice their own health explanations, expectations, and worries (Pavlish, et al., 2010).

Summary

This review of the literature has identified a gap in knowledge regarding the mental health care perceptions, beliefs, practices, and needs of Somali immigrants. As discussed earlier in this review, the people of Somalia have faced many struggles over the last twenty years that have predisposed them to mental health disorders and placed them in great need of culturally congruent mental health care and treatment. However, as

demonstrated in this comprehensive review of the literature, very little research has been conducted that has looked at the mental health care perceptions, beliefs, practices, and needs of the Somali people. Many Somali refugees chose Minnesota as their home, yet most of the limited mental health care studies that have been conducted were done in countries outside of the United States. The studies that have been done outside the United States have very limited information that can be used in providing culturally congruent care to the Somali population in the United States. Three research studies found in the literature were conducted in Minnesota, but one focused on obstetric care, another on gender differences in psychiatric symptom presentation and diagnosis, and the third involved only women, was not at all specific to mental health, and thus yielded very little Somali immigrant mental health care data. Research studies are needed that will investigate the mental health care perceptions, practices, beliefs, and needs of Somali immigrants in Minnesota so that culturally congruent mental health care practices for this population can be provided. A qualitative ethnonursing study guided by Leininger's theory of Culture Care Diversity and Universality that was conducted with the purpose of increasing the understanding of the indigenous Somali mental health care systems so Somali beliefs and practices could be incorporated into professional nursing practice to provide nursing decisions and actions needed to provide culturally congruent mental health nursing care to the Somali immigrants.

Guiding Framework

Care is embedded in the worldview, social structure, and values of each specific culture (Leininger & McFarland, 2006), and has been described in the majority of nursing models and theories. Transcultural nursing care focuses on the practice and study of

culture care differences and similarities among and between cultures to help people maintain and attain meaningful and therapeutic health care practices that are culturally based (Leininger & McFarland, 2006). Leininger's theory of Culture Care Diversity and Universality was chosen to guide this study because of its congruence with the ethnonursing methodology. The ethnonursing methodology is the most appropriate methodology to answer the research questions that were developed from the researcher's awareness of issues related to clinical work experience.

Central to the practice of transcultural nursing is the influence of culture on the nurse–client relationship (Sitzman & Wright Eichelberger, 2004). Leininger independently developed the Theory of Culture Care Diversity and Universality to discover the care and health needs of diverse cultures (Leininger & McFarland, 2006). Leininger coined the term 'culturally congruent care', which is the foremost goal of transcultural nursing. Leininger's theory provides guidance for nursing care actions and decisions that are in accord with a person's cultural beliefs, practices, and values. The theory holds that culturally congruent care is possible when a nurse and client creatively work together and design a new and different care lifestyle for the health and well-being of the client within the nurse-client relationship (Leininger & McFarland, 2006).

Leininger developed and defined terms that are central to understanding her theory. A brief description of the terms adapted from Leininger and McFarland (2006) that will contribute to the theory's guidance of this research study is as follows:
• *Care* is to assist others with real or anticipated needs in an effort to improve a human condition of concern (adapted from Leininger & McFarland, Chapter 1).

• *Culture* refers to learned, shared, and transmitted values, beliefs, norms, and lifeways of a specific individual or group that guide their thinking, decisions, actions, and patterned ways of living (adapted from Leininger & McFarland, Chapter 1).

• *Cultural care* refers to multiple aspects of culture that influence and enable a person or group to improve their human condition or to deal with illness (adapted from Leininger & McFarland, Chapter 1).

• *Cultural care diversity* refers to the differences in meanings, values, or acceptable modes of care within or between different groups of people (adapted from Leininger & McFarland, Chapter 1).

• *Cultural care universality* refers to common care or similar meanings that are evident among many cultures (adapted from Leininger & McFarland, Chapter 1).

• *Worldview* refers to the way people tend to look at the world or universe in creating a personal view of what life is about (adapted from Leininger & McFarland, Chapter 1).

• *Cultural and social structure dimensions* include factors related to religion, social structure, political/legal concerns, economics, educational patterns, use of technologies, cultural values, and ethnohistory that influence cultural responses of human beings within a cultural context (adapted from Leininger & McFarland, Chapter 1).

• *Health* refers to a state of well-being that is culturally defined and valued by a designated culture (adapted from Leininger & McFarland, Chapter 1).

• *Cultural care preservation or maintenance* refers to nursing care activities that help people of particular cultures to retain and use core cultural care values related to healthcare concerns or conditions (adapted from Leininger & McFarland, Chapter 1).

• *Cultural care accommodation or negotiation* refers to creative nursing actions that help people of a particular culture adapt to or negotiate with others in the healthcare community in an effort to attain the shared goal of an optimal health outcome for client(s) of a designated culture (adapted from Leininger & McFarland, Chapter 1).

• *Cultural care repatterning or restructuring* refers to therapeutic actions taken by culturally competent nurse(s) or family. These actions enable or assist a client to modify personal health behaviors towards beneficial outcomes while respecting the client's cultural values (adapted from Leininger & McFarland, Chapter 1).

There are also several specific assumptions that are inherent in Leininger's theory that support the theory and the use of the previously listed terms. These assumptions are the philosophical underpinnings of Leininger's Culture Care Diversity and Universality theory. The inherent assumptions viewed as relevant for this research study as taken from Leininger and McFarland (2006) is as follows:

• Every human culture has folk remedies, professional knowledge, and professional care practices that vary. The nurse must identify and address these factors consciously with each client in order to provide holistic and culturally congruent care (adapted from Leininger & McFarland, Chapter 1).

• Cultural care values, beliefs, and practices are influenced by worldview and language, as well as religious, spiritual, social, political, educational, economic, technological, ethnohistorical, and environmental factors (adapted from Leininger & McFarland, Chapter 1).

• Beneficial, healthy, satisfying culturally based nursing care enhances the well-being of clients (adapted from Leininger & McFarland, Chapter 1).

• Culturally beneficial nursing care can only occur when cultural care values, expressions, or patterns are known and used appropriately and knowingly by the nurse providing care (adapted from Leininger & McFarland, Chapter 1).

• Clients who experience nursing care that fails to be reasonably congruent with the client's cultural beliefs and values will show signs of stress, cultural conflict, noncompliance, and ethical moral concerns (adapted from Leininger & McFarland, Chapter 1).

Leininger's Theory of Culture Care Diversity and Universality holds that culturally congruent care is possible when a nurse and patient creatively work together and design a new and different care lifestyle for the health and well-being of the patient within the nurse-patient relationship (Leininger & McFarland, 2006). According to Leininger's theory, the nurse-patient relationship that utilizes culturally competent care will have a positive effect and support healthy changes in healthcare practices for patients of selected cultures, but the patient's beliefs and values must be thoughtfully and skillfully incorporated into the nursing care plan. Commitment to practicing using culturally competent care offers great satisfaction and personal rewards to those who can provide this holistic care to patients (Leininger & McFarland, 2006). Leininger's theory of Culture Care Diversity and Universality will be used as a guide while conducting this research study involving Somalis as it lends itself well to providing direction in working with an identified cultural group and focusing on providing culturally competent care.

Leininger's qualitative ethnonursing research method is the preferred selection for a research study in the identified cultural group. This qualitative ethnonursing research method was developed to document and gain greater understanding and meaning of

people's life experiences (Leininger and McFarland, 2002). According to Leininger, the goal of ethnonursing is to discover new nursing knowledge as experienced or perceived by consumers of nursing and health services, which makes it a good fit for this area of interest. Using this research framework's Sunrise Enabler, Observation-Participation-Reflection Enabler, and the Stranger to Friend Enabler concepts can provide a foundation that guides the researcher in the understanding of culture care experiences during research studies (Hubbert, 2005). The enablers are tools for the researchers that enhance the ability to gain knowledge of how an identified group knows and experiences life (Hubbert, 2005). Using Leininger's theory of Culture Care Diversity and Universality to guide research in combination with Leininger's qualitative ethnonursing research method in a study founded in discovering the perceptions of mental health and illness of Somalis is quite fitting, as this approach provides direction, support, and structure for this research. This combination would also provide the methodological congruence that is essential in conducting research.

This study identified that mental health culture care meanings, beliefs and practices of the Somali people are rooted in the multiple factors of the Sunrise Enabler. With the assumptions of the Culture Care Theory and the ethnonursing method with its enablers guiding the research process, a perspective of the mental health care meanings, expressions and experiences of the Somali people and possible influences upon mental health and illness, was discovered. The Culture Care Diversity and Universality Theory and ethnonursing method enabled the discovery of original knowledge in relation to the perception of mental health and illness in the Somali culture.

Summary. Leininger's theory of Culture Care Diversity and Universality was the guiding theoretical framework for the study. Leininger's theory is an appropriate choice for research involving Somali immigrants and their perceptions of mental health and illness because the theory provides a guiding framework when conducting research with an identified cultural group and gaining understanding of nursing's roles in providing care to a specific group (Leininger & McFarland, 2006). According to Leininger's theory, all cultures of the world possess indigenous mental health care beliefs and practices, and of course this would include the Somali culture as well. Disregarding cultural beliefs and practices is not good practice and could result in poor mental health outcomes. If Somali mental health beliefs and practices could be better understood through research guided by Leininger's theory of Culture Care Diversity and Universality, they could be incorporated with professional care systems to ensure that the Somali people receive culturally meaningful mental health care.

CHAPTER III

STUDY DESIGN

Interest in Transcultural Nursing

The researcher became interested in transcultural nursing and transcultural nursing research after beginning practice as an advanced practice mental health nurse in a large inner city county hospital that serves a culturally diverse population. This researcher also participated in a cultural immersion experience in Italy that accentuated that the phenomena of culture, cultural congruence, and cultural diversity are complex issues with multiple opportunities for new knowledge development. The experience resulted in the researcher becoming the lead author of a manuscript prepared for publication following this experience (See Appendix A). The interest in the Somali population grew with this researcher's clinical experiences at the hospital.

Entry into the Field

The researcher visited the Karmel Somali mall (a mall with many small Somali run shops in a large Minnesota city) on numerous occasions and participated in many field observations at this public mall. The researcher also made many observations while working clinically and caring for mentally ill hospitalized Somali patients. The researcher talked with Somali staff that work at the same hospital as the researcher as well. One of the nurses at the hospital agreed to serve as a gatekeeper for the study. The Stranger-Friend Enabler was utilized to assess the researcher's relationship with the informants.

Methodology

Leininger's qualitative ethnonursing research method was used for this study. The qualitative ethnonursing research method was developed to document and

gain greater understanding and meaning of people's life experiences (Leininger, 2002).

Ethnonursing methods are useful in studying and analyzing people's viewpoints, beliefs,

and practices about nursing care phenomena and processes of specific cultures

(Leininger, 2002). According to Leininger, the goal of ethnonursing is to discover new

nursing knowledge as experienced or perceived by consumers of nursing and health

services, as well as nurses, which makes it a good fit for this study. The ethnonursing

method utilizes Leininger's theory of Culture Care Diversity and Universality as a guide

for understanding culture care experiences (Leininger, 2002). Using this theory's Sunrise

Enabler, Observation-Participation-Reflection (O-P-R) Enabler, and the Stranger to

Friend (S-F) Enabler can provide a foundation that guides the researcher in the

understanding of culture care experiences during research studies (Hubbert, 2005). The

enablers are guides for the researchers that enhance the ability to gain knowledge of how

an identified group knows and experiences life (Hubbert, 2005). Leininger's ethnonursing

enablers were used by the investigator to gain access to and to be trusted within the

domain. These are discussed further individually below.

  Sunrise Enabler. Leininger developed the Sunrise Enabler as a cognitive

research guide to assist researchers in pulling out culture care phenomena from a holistic

perspective of multiple factors that have the potential to influence the care and well-being

of people (Leininger & McFarland, 2002). Through interviews with informants, the

researcher explores the dimensions of the tool which include technological factors,

educational factors, religious and philosophical factors, economic factors, political and

legal factors, kinship and social factors, as well as cultural values, beliefs, and life ways

(See Appendix B). The detailed holistic approach of the Sunrise Enabler assists a

researcher in systematically and rigorously discovering culture care meanings, beliefs and practices of the informants. The Sunrise Enabler was utilized in this study to develop interview questions that focused on mental health cultural values, beliefs, and life ways.

The observation-participation-reflection (O-P-R) enabler. Observations began with the investigator establishing her interest in the population and socially exploring the community facilities with high Somali immigrant populations as identified by the gate keeper. Field notes of observations were kept. It was important for the researcher to become a participant in the activities of the community (See Appendix C). The investigator was then able to identify potential key and general informants through reflection of the observations and notes.

The stranger to trusted friend (S-F) enabler. Simultaneously to using the O-P-R enabler, the S-F enabler was used by the researcher, as becoming a trusted friend was essential for conducting the interviews in this study (See Appendix D). As a trusted friend, the researcher was in a position to obtain authentic, credible, and dependable data. The researcher conducted a minimum of one interview lasting 1 to 2 hours with each general informant (and an interpreter if indicated). General informants that were found to be knowledgeable and conversant regarding the DOI were distinguished as key informants. One to 2 additional interviews lasting 1 to 2 hours were conducted with key informants as indicated to confirm and explicate the data patterns. Observational and interview data were recorded with written field notes, and when the informant agreed, the interviews were audio taped. The investigator then input the field note and transcript data into Nvivo9 data manager program to assist with storage and management of the data. Somali interpreters were utilized as necessary.

A semi-structured open-ended interview guide was used to direct the interviews (See Appendix E). The interview was developed with guidance from Leininger's Sunrise Enabler and interview guide (Leininger and McFarland, 2002). To begin an interview, a description of the purpose of the study was given to the informants, and the researcher provided an opportunity for informants to ask questions and clarify any concerns they had related to the study. If a participant agreed to participate in the study, a consent form was provided in either English or Somali, depending on their preference. The informants were asked to read and sign the consent form. Informants were assured of confidentiality of all information prior to beginning an interview. The researcher began the interviews by eliciting demographic information and general information related to Somali cultural lifeways. The informant responses guided the interview content, as the researcher examined responses in relation to the facets of the Sunrise Model. One or two follow up interviews were conducted with key informants as indicated so the researcher could validate and refine thematic extractions and inferences about culturally congruent care modes of actions. Through interviews, field notes, and a review of transcribed tape recordings, the researcher was able to discover, describe and analyze the meanings, beliefs and practices of care for Somali immigrants, and identify care practices that enhance or hinder mental health and wellbeing for this cultural group.

Ethnonursing interviewing. This study focused on documenting and analyzing meanings, expressions and experiences of mental health care, and discovering the mental health care practices that hinder or enhance mental health and wellbeing for Somali immigrants. Therefore, in-depth interviewing was an essential part of the ethnonursing research process. Ethnonursing interviewing is different from interviewing with survey or

quantitative types of research, thus an unstructured format was used as a general guide to open inquiry. The investigator used a semi-structured interview guide developed with direction from Leininger's sunrise model to conduct the interviews with the general informants. The questions were not read verbatim, but served as a guide for the researcher and the guide was revised based on the findings as the study progressed. As the interviews and study unfolded, the informants and the data guided the direction of the interview.

Throughout the process, the researcher clarified core meanings and experiences of the informants to establish credibility and accuracy of data. Further interviews with key informants were conducted as indicated to confirm and explicate the care patterns. Observational data obtained from observing the environment and nonverbal communication of the informants was recorded with written field notes. Interview data was audio-tape recorded if the informant gave permission. If it was problematic for informants to be audio taped, in-depth notes were used to capture the interview. The informants were interviewed at a location of their choosing. The informants were given a $10 gift card for Walgreen's for their participation in the study. Participants were also given $10 gift cards to Walgreen's for any additional individual interviews. Key informants were asked to participate in a second, and sometimes even a third, interview for clarification and confirmation of the data.

Setting. The study was conducted in an urban community in Minnesota that is known to have a large Somali immigrant population. Community and private facilities identified by the gate keeper and key informants were utilized.

Selection of informants.   A volunteer convenience sample of informants was chosen using the snowball method. The general informants were chosen with the assistance of gate keepers. Two gatekeepers assisted the researcher with recruitment activities, however; only the study researcher was responsible for explaining the study and obtaining informed consent. The gatekeepers approached possible informants and provided them with the researchers contact information. The researcher discussed the study with interested potential informants and set up an interview place and time. The initial informants were asked if they knew others in the community who might know something about the topic of the interview and they were invited to recommend those individuals to participate in the study. The informants provided other potential informants with the researcher's contact information. The potential informants then contacted the researcher if interested in participating in the study.

For this study, Leininger's ethnonursing method was chosen because it uses an inquiry approach within the qualitative paradigm to uncover the emic (insider's) view as well as the etic (outsider's) perspective of culture care phenomena. Leininger suggested that key informants and general informants be selected to obtain in-depth knowledge to fully understand the phenomena under study (2002). Key informants were fully knowledgeable about the norms, values, beliefs and general lifeways of the culture, while general informants were selected to get a view of how similar or different their ideas are from the key informants. Leininger suggests 12-15 key informants are needed for a study. Leininger also proposes that approximately twice the numbers of general informants to key informants are needed. General informants were interviewed for approximately 60 minutes. After the first several interviews, key informants were selected based on their

increased knowledge related to the richness of information pertaining to the DOI and ability to provide confirmation of the data.

Criteria for selection as a general informant included:

1. Self-reported that they are a Somali immigrant.

2. Willing and able to share information and knowledge related to the DOI.

3. Agreed to be interviewed at least once by the researcher for 1 to 2 hours.

4. Male or female over the age of 18.

5. Spoke either English or Somali, as a Somali interpreter was made available to those informants that preferred to speak Somali.

Criteria for selection as a key informant included:

1. Self-reported that they are a Somali immigrant.

2. Willing and able to share information and knowledge related to the DOI.

3. Agreed to be interviewed up to 2-3 times by the researcher for 1 to 2 hours at a time.

4. Male or female over the age of 18.

5. Spoke either English or Somali, as a Somali interpreter was made available to those informants that preferred to speak Somali.

6. Identified by the researcher as having increased knowledge of the DOI and the ability to provide confirmation of the data.

The general informants were chosen with the assistance of a gate keeper. Two Somali psychiatric nurses that work for the local hospital agreed to serve as gate keepers, as well as informants. A male gate keeper and a female gate keeper were needed to access both gender groups as interactions with an opposite sex person is not common in this population. They were both a good fit as both gate keepers and informants as they

were working as nurses with mentally ill patients, were interested in increasing nursing's knowledge of the Somali culture, were known in the population of interest, and were still practicing traditional Somali cultural dress, beliefs and practices. The inclusion criteria for this study were Somali immigrant adults over the age of 18 that were able to tolerate and comprehend questions during an hour to two hour interview. The ability to tolerate and comprehend interview questions in either English or Somali was determined by information gathered from the gate keeper, and further confirmed by the researcher during the initial contact with the informant.

One 1 to 2 hour interview was conducted with each general informant. In this first interview, the researcher used the interview guide to explore and identify care meanings, beliefs and practices. Depth of the data obtained from these first interviews with general informants guided the researcher to identification of key informants. Additional interviews were conducted with key informants as indicated once review of interview data was underway and identification of key informants was made. In the second or third interview with key informants, the researcher verified the information from previous interviews and explored and validated care practices that may hinder or enhance mental health and wellbeing for immigrant Somalis. Second and even third interviews were conducted as indicated in order to assure the data was valid and to offer further opportunity for informants to add information.

Human Subjects and Ethical Considerations

The researcher was diligent in her awareness of ethical considerations throughout the inquiry processes of this research study. Every effort was made to protect the human rights and confidentiality of this study's vulnerable informants by informing them of the

study and their ability to withdraw if desired at any time. Consent forms were at a sixth grade reading level and translated into Somali for the informants that preferred the consent in their native language (See Appendix F). Two copies of the consent form were presented to the informant for signature; researcher witnessed the signature. One copy was given to the informant and one copy remains on file. The study was approved by Duquesne University's IRB. Data collection was performed in a manner as to not disrupt normal community activities. Although all informants tolerated the interviews without difficulty, in the event that an interview would have appeared to be negatively affecting the mental health of the informant, the interview would have been stopped and a referral to a mental health provider made if appropriate. Anonymity of all informants past contact with the interviewing researcher was assured through the use of aliases that they may choose.

The data collected in this study was used solely by this researcher for the purpose stated in the proposal, and are securely stored in a locked drawer in the researcher's office. The data was kept separate from the consent forms to protect the informants' identities. Data will be destroyed five years after all aspects of this study have been completed. The gate keepers, as well as the interpreter utilized, also signed a confidentiality form that was secured in a locked drawer in the researcher's office (See Appendix G). Any risks associated with the study were believed to be minimal and no greater than every day activities. All informants provided informed consent prior to any data collection, at the original face-to-face meeting. Data was stored in the qualitative data manager Nvivo9. All steps of the analytic process were documented. All documents were reviewed for accuracy.

Method of Data Analysis

Leininger's four phases of analysis for qualitative data were utilized (Leininger & McFarland, 2002, 2006). These are described in more detail below.

Collecting, describing, and documenting raw data. In this first phase of data analysis, the researcher collected, described, and recorded data related to the purpose and research questions. Interview data from the informants was recorded, observations were made, participatory experiences occurred, contextual meanings identified, preliminary interpretations made, symbols identified, and data recorded with an emic focus, but including attention to etic data as well. The data from the full and condensed field notes was put into the computer for management.

Identification and categorization of descriptors and components. During the second phase of data analysis, data was coded and classified. Emic and etic descriptors were studied for similarities and differences, and recurrent components were studied for meanings.

Pattern and contextual analysis. During the third phase of data analysis, data was inspected closely to discover saturated ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, and explanations. Data was examined to show patterning in meanings, along with further credibility and confirmation of findings.

Major themes, research finding, theoretical formulations, and recommendations. During this fourth and final stage, the highest phase of data analysis, synthesis, and interpretation occurred. Synthesis of thinking, configurations, analysis, interpreting findings, and creative formulations from data of the previous phases

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occurred. Abstraction and the presentation of major themes, findings, and recommendations was the obtained goal of this phase

Substantiation of the Research

The study design included several components that ensured rigor and credibility: 1) the study investigator and advisor served as readers and auditors for the data collection and analysis; 2) a comprehensive audit trail was kept of all decisions and techniques; and 3) emerging analysis (comprised of themes and categories). The analysis involved the concurrent process of collecting, coding, categorizing, and interpreting data. Open, line-by-line coding was used, whereby patterns in the data were identified, codes that resemble each other clustered, and clusters examined for themes.

Leininger and McFarland (2006, Chapter 2) offers six criteria for substantiation of ethnonursing research: *credibility, confirmability, meaning-in-context, recurrent patterning, transferability and saturation.* Evaluation of the quality and rigor of this study was done using these criteria.

Credibility is essential in qualitative research and refers to the truth, accuracy, and believability of the findings that have been mutually established by the researcher and the informants as accurate, believable, and credible of the experiences and knowledge of phenomena (Leininger & McFarland, 2006, Chapter 2). The meanings, beliefs and practices of Somali immigrants was substantiated through the researcher's observations and data analysis. Confirmability refers to repeated direct and documented objective and subjective data that is confirmed by the informants (Leininger & McFarland, 2006, Chapter 2). The researcher maintained all the records and field notes obtained through the research process. The researcher reflected upon the data collected and discussed it with

the informants during subsequent interviews to confirm or clarify the interpretation of the findings. When writing the research report, as special effort was made to keep the information given by the informants unchanged. Data was collected until saturation of the data occurred. Saturation was achieved when there was a redundancy of information in which the researcher got the same or similar information, and the informants reported that there was no more to offer as they had shared everything (Leininger & McFarland, 2006, Chapter 2).

Meaning-in-context refers to the importance of the data becoming understandable with relevant meanings to the informants within their environmental context (Leininger & McFarland, 2006, Chapter 2). This criterion focuses on the significance and understanding of interpretations. The researcher needs to understand the situations and activities described and transfer them to a wider context. The researcher interviewed informants in different environments and situations to get a wide knowledge of the community. The researcher explored the research as a whole to explicate the meaning of the data from the immigrant Somali perspective and the impact on the DOI. When writing the research report, effort was made to keep the information given by the informants unchanged. Recurrent patterning refers to repeated instances, patterns of expression, and patterned occurrences that reoccur over time in designated ways (Leininger & McFarland, 2006, Chapter 2). Repeated experiences, expressions, events, or activities that reflect identifiable sequenced patterns of behavior over time validate this criterion. The researcher interviewed different people in different informant identified environments to gain information about different aspects of the phenomena.

Transferability refers to whether or not the findings of the study have similar meanings and relevance in another similar situation or context (Leininger & McFarland, 2006, Chapter 2). While the goal of qualitative research is not to obtain generalizations, but instead to obtain in-depth knowledge, this criterion looks for any general similarities of findings under similar environmental conditions or contexts. The data in this study was collected in a single community with a large Somali population. However, the interpretations of care meanings, beliefs and practices, based on the lay interpretations of care, may be transferred to some other Somali immigrant cultural contexts, but not all Somali immigrant circumstances. The study has another recognizable limitation. Communication problems can occur when working with interpreters, especially if they do not have a good understanding of the topic area. There could have been some communication problems as interpreters were utilized for this study. However, only the gate keepers served as interpreters in this study and they both have a good understanding of mental health terms since they both work with mentally ill patients. Also, to decrease communication problems, a male and a female gate keeper were utilized as it is uncommon, and sometimes even unacceptable, for people of the opposite sex to interact with each other in this population.

Summary

This study discovered mental health care meanings, beliefs, and practices for Somali immigrants living in a Minnesota community with a large Somali population as they are influenced by shared cultural values, beliefs and practices. The informants revealed unknown dimensions related to mental health care perceptions, meanings, beliefs, and practices. This study was conceptualized within the framework of

Leininger's Culture Care Theory and ethnonursing method which guided the researcher to obtain valid and rich data. The findings of this study contributed to transcultural nursing knowledge related to the Somali culture and the mental health meanings of care for Somali immigrants. The knowledge gained can improve nursing and provider care decisions and actions so that culturally congruent care is provided for the Somali immigrant culture group.

CHAPTER IV

Manuscript Prepared for Publication

Abstract

Purpose: Knowledge of Somali immigrants' mental health care beliefs and practices is needed so nurses can provide culturally congruent care. The purpose of this study was to explore, discover, and understand the mental health meanings, beliefs, and practices from the perspective of immigrant Somalis. **Design/Method:** Leininger's qualitative ethnonursing research method was used. Thirty informants (9 key and 21 general) were interviewed in community settings. Leininger's ethnonursing enablers and four phases of analysis for qualitative data were utilized. **Results:** Analysis of the interviews revealed 21 categories and 9 patterns from which 2 main themes emerged. The themes are (a) significant influences of religion on health and care and (b) tribe connectedness, cultural history, and khat usage are significant in health care. **Discussion/Conclusions:** Somali cultural and religious beliefs and practices influence their healthcare choices.

Implications for Practice: The findings will improve care by promoting culturally congruent care for the Somali immigrant population.

Introduction

According to Scuglik, Alarcón, Lapeyre, Williams, and Logan (2007), the mental health needs of immigrants in the United States are a crucial aspect of today's health care arena. They assert that even if the acculturation process follows a conventional course, the outcome is complicated by the impact of pre-migration losses, traumatic events, and adapting to differences in weather, religion, language, clothing, legal principles, and financial pressures, all of which carry substantial mental health implications (Scuglik et al., 2007). Knowledge of immigrants' mental health care beliefs and practices is needed to assist caregivers with understanding the population so they can provide culturally congruent mental health care. A review of the literature identified a gap on the subject of Somali immigrants' perception of mental health and illness. A qualitative ethnonursing study with the purpose of exploring, discovering, and understanding the mental health meanings, beliefs, and practices from the perspective of immigrant Somalis living in the United States was designed. The goal of this study was to assist caregivers to plan and implement nursing decisions and actions that promote culturally congruent mental health care for Somali immigrants.

The domain of inquiry (DOI) for this study was the mental health care meanings, beliefs and practices of Somali immigrants within the context of an urban Minnesota city that has a large number of Somali immigrants. This research study's DOI was investigated through semi-structured interviews with informants designed to answer the study's research questions. The research questions that guided the study were: 1) What are the care beliefs and experiences of mental health for Somali immigrants living in the US? 2) What are the care beliefs and experiences of mental illness for Somali immigrants

living in the US? 3) What are the nursing actions and decisions to promote mental health for Somali immigrants in the US? 4) What are the nursing actions and decisions in caring for mentally ill Somali immigrants in the US?

Literature Review

Somalia is a country in Eastern Africa that borders the Gulf of Aden and the Indian Ocean. Somalia, unlike many of the other African countries, is composed of a principally homogeneous ethnic group that shares a common language, religion and culture and can trace their heritage to a common ancestry (U.S. Department of State, 2011). According to Brons (2001), Somalia has been without a single government entity since 1991 when the state collapsed at the climax of the civil war as numerous clan-affiliated groups had joined forces to take control of most of the country. These victorious groups were not able to unite in forming a new government, and as a result, different military group leaders exercise politico-military dominance over particular territories, the boundaries remain unsettled, and sporadic fighting and political maneuvering continue up to the present time (Brons, 2001). Numerous Somalis were forced to leave Somalia, and others fled the country due to continued unrest and moved to camps in neighboring countries, such as Kenya (Brons, 2001). Many Somali immigrants came to the United States from these camps with the assistance of charity organizations.

Need for Research

The people who emigrated from Somalia have faced many struggles over the last twenty years that have predisposed them to mental health disorders and placed them in great need of culturally congruent mental health care and treatment. However, little research has been conducted that has looked at the mental health care beliefs, practices,

and needs of the Somali people. A few pertinent research studies on Somali mental health issues have been conducted and were found in the literature. Kroll, Ysuf, and Fujiwara (2010) observed an unusually high number of young Somali men presenting as psychotic to a community clinic in Minnesota. They conducted a research study to investigate the major patterns of psychiatric disorders in the Somali outpatient population and determined that more research in Somali mental health was needed, including research to investigate causative and contributory risk factors to explain the high rates of psychoses among young Somali men.

Research Demonstrating Obstacles to Somali Mental Health Care

According to Pavlish, Noor, and Brandt (2010), despite the need, very few studies to date have been conducted on African immigrant groups. Boynton, Bentley, Jackson, and Gibbs (2010) report that there is a cultural unfamiliarity with the concept of mood disorders in the Somali explanatory model of mental illness. For Somalis, the concept of mental health has traditionally been divided into categories of "sanity" and "insanity", and people who demonstrate psychosis and are either violent or have behaviors that cannot be controlled are labeled "insane." Warfa et al. (2006) conducted a qualitative research study with the purpose of exploring the meaning of geographical mobility for Somali professionals and refugees living in London, UK. The researchers specifically examined how geographic mobility might relate to mental health status and health service use and reported that "migration" is associated with poor health outcomes for certain marginalized and socially disadvantaged populations.

Scuglik et al. (2007) report that Somalis rarely acknowledge psychiatric problems and common traditional treatments for psychiatric symptoms have become ineffective in

their new lives. These researchers reviewed demographic data from the Minnesota Department of Human Services, interviewed health professionals, and also explored community perceptions of medical and psychiatric needs, cultural characteristics, barriers to care, and potential solutions. The survey identified language barriers (74%), and cultural misperceptions (68%) as the most frequent obstacles to providing mental health care. Whittaker, Hardy, Lewis, and Buchan (2005) conducted a cross-sectional study with the aims of exploring individual and collective understandings of psychological well-being among young Somali asylum-seeker or refugee women in Northern England. They discovered that the stress of conflicting and changing cultural and religious positions, as well as their desire to conceal distress, create barriers to accessing support.

Theoretical Guide

Leininger's theory of Culture Care Diversity and Universality was the guiding framework for the research study as it provides the best framework when conducting research with an identified cultural group to gain understanding of nursing's roles in providing care (Leininger & McFarland, 2002, 2006). Disregarding cultural beliefs and practices is not good practice and could result in poor mental health outcomes. If Somali mental health beliefs and practices could be better understood through research guided by Leininger's theory of Culture Care Diversity and Universality, they could be incorporated with professional care systems to ensure that the Somali people receive culturally meaningful mental health care.

Method

Leininger's qualitative ethnonursing research method was used for this study. It was developed to document and gain greater understanding and meaning of people's life

experiences and is useful in studying and analyzing people's viewpoints, beliefs, and practices about nursing care phenomena and processes of specific cultures (Leininger & McFarland, 2002, 2006). Using this method's Sunrise Enabler, Observation-Participation-Reflection (O-P-R) Enabler, and the Stranger to Friend (S-F) Enabler concepts provided a foundation that guided the researcher in the understanding of culture care experiences during the research study (Hubbert, 2005).

Human Subjects Approval and Recruitment

Following institutional review board approval, initial recruitment occurred through recruitment activities involving two gate keepers. The researcher then met with the elders in the community (under the encouragement of the male gate keeper) to obtain their approval to conduct the study in the community. A female gate keeper was also utilized as most people in this community view it more appropriate and comfortable to have a same gender gate keeper. The initial informants then invited others in the community were interested in participating in the study. The informants comprised of a voluntary convenience sample that self-identified as Somali immigrant adults over the age of 18 that were able to tolerate an interview (Table 1).

Informants

The study was conducted in an urban community in Minnesota that is known to have a large Somali immigrant population. The informants self-identified as immigrants (people electing to immigrant into the United States) as opposed to refugees (people forced to leave their country of origin due to political issues). Thirty-five percent of all Somali primary immigrants entering into the United States in 2000 settled in Minnesota, and many more then migrated to the state from other areas, resulting in the Somali

population estimates for Minnesota ranging from 15,000 to 40,000 (Burke, 2005). Some Somali professionals in the community estimate that the numbers are now much higher, ranging from 70,000 to 100,000 (Associated Press, 2010). The two types of informants required by the ethnonursing method, key (n = 9) and general (n = 21), were utilized (Leininger & McFarland, 2002, 2006) and interviewed until saturation of data occurred. Key informants were chosen for the depth of their knowledge and willingness to share openly with the researcher. The sample (n = 30) consisted of 22 females and 8 male informants aged 22 to 62 years (M = 28 years, SD = 11.3) that immigrated between 6 and 15 years prior to their interviews (median = 12 years). All informants reported speaking Somali as the main language in their home and English as one of the second languages spoken in their home.

Interviews

After giving written consent, each informant participated in a 60- to 90-minute interview with a semi-structured open-ended questions related mental health beliefs and practices. Many of the interviews were audio recorded, although almost half of the informants requested that the researcher take notes instead. Gatekeepers served as interpreters as necessary. All key informants were approached a second time to clarify and verify the information being gathered. The researcher conducted all interviews in informant-chosen locations including workplaces (16) and community centers (14). The researcher transcribed all audio recorded interviews and kept detailed field notes. To maintain confidentiality, identifying information was removed during transcription. Transcribed and recorded data were separately stored in a locked filing cabinet. The

information was stored and managed in Nvivo 9 data manager. Leininger's ethnonursing enablers were used by the investigator and are discussed further individually below.

Sunrise enabler. Leininger developed the Sunrise Enabler as a cognitive research guide to assist researchers in pulling out culture care phenomena from a holistic perspective of multiple factors that have the potential to influence the care and well-being of people (Leininger & McFarland, 2002, 2006). Through interviews with informants, the researcher explored the dimensions of the tool which include technological factors, educational factors, religious and philosophical factors, economic factors, political and legal factors, kinship and social factors, as well as cultural values, beliefs, and life ways. The detailed holistic approach of the Sunrise Enabler assisted the researcher in systematically and rigorously discovering culture care meanings, beliefs, and practices of the informants, and was utilized when developing the interview guide.

The O-P-R Enabler. According to Leininger and McFarland (2006, Chapter 1), the O-P-R enabler guides the researcher in observing informants in their natural environments. Observations began with the researcher establishing her interest in the population and socially exploring the community facilities with high Somali immigrant populations. Field notes were kept. The researcher participated in the activities of the community, shopping at the Somali mall and visiting the community centers. Potential informants were identified.

The S-F Enabler. Simultaneously to using the O-P-R enabler, the S-F enabler was used by the researcher, as becoming a trusted friend was essential for conducting the interviews in this study. As a trusted friend, the researcher was in a position to obtain authentic, credible, and dependable data (Leininger & McFarland, 2002, 2006).

Data Analysis

Leininger's four phases of analysis for qualitative data were utilized (Leininger & McFarland, 2002, 2006). In this first phase of data analysis, the researcher collected, described, and recorded data related to the purpose and research questions. Interview data from the informants was recorded, observations were made, participatory experiences occurred, contextual meanings identified, preliminary interpretations made, symbols identified, and data recorded with an emic focus, but including attention to etic data as well. The data from the full and condensed field notes was put into the computer for data management. During the second phase of data analysis, data was coded and classified. Emic and etic descriptors were studied for similarities and differences, and recurrent components were studied for meanings. During the third phase of data analysis, data was inspected closely to discover saturated ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations. Data was examined to show patterning in meanings, along with further credibility and confirmation of findings.

During the fourth and final stage, the highest phase of data analysis, synthesis, and interpretation occurred. Synthesis of thinking, configurations, analysis, interpreting findings, and creative formulations from data of the previous phases occurred. Abstraction and the presentation of major themes, findings, and recommendations occurred. The data was stored in Nvivo 9 data manager program to assist with storage and management.

Leininger and McFarland (2006, Chapter 2) offer six criteria for substantiation of ethnonursing research: credibility, confirmability, meaning-in-context, recurrent

patterning, transferability and saturation. Evaluation of the quality and rigor of this study was done using these criteria. Data was collected until saturation occurred as categories and patterns emerged, and the observations and interviews no longer produced new information. Confirmability was accomplished by seeking feedback, clarification, and verification on information gathered from key informants. Credibility was substantiated through the researcher's observations and data analysis. Meaning-in-context was established as the researcher explored the research as a whole to explicate the meaning of the data from the immigrant Somali perspective and the impact on the DOI. Recurrent patterning was accomplished as the researcher interviewed different people in different informant identified environments to gain information about different aspects of the phenomena. Transferability occurred as well because the interpretations of care meanings, beliefs and practices, based on the lay interpretations of care, may be transferred to some other Somali immigrant cultural contexts.

Results

Simultaneous data collection and analysis resulted in changes in the open-ended interview guide, helped determine which areas needed more in-depth exploration in remaining interviews (Leininger and McFarland, 2002, 2006), and resulted in a collection of information that was presented to key informants for verification and clarification. The data was organized into twenty one initial categories, which after closer examination and study, resulted in these categories being organized into nine patterns. These patterns were then analyzed and synthesized and two major themes emerged (Table 1). The influence of a Somali immigrant's religion on their health and mental health beliefs and practices became quite apparent as every informant identified the influence of religion on a

person's health and well-being, as well as identifying religious practices as the first line treatment for any disease process. Cultural influences such as trust, history of trauma, and language barriers also influence their presence and participation in the healthcare systems.

Pattern and Theme Abstraction

Data analysis of general and key informant interviews, observations in healthcare and community settings, and discussions with gate keepers and elders, resulted in nine patterns of similar meanings that were further explored, interpreted, and synthesized. Creative formulations were abstracted during this final phase of data analysis and resulted in the emersion of two major themes and recommendations for the future. Patterns including the importance of elders, generational and gender differences, communication issues, care and wellbeing values, appreciation of care in American and/or Minnesota, and cultural care issues incorporating history of past trauma, importance of respect, khat usage, "evil eye", "black magic", trust issues, and tribe/family involvement are cultural care issues that influence health beliefs, values, and practices in the Somali culture. Patterns including the importance and influence of religion, effects of prayer and feelings of closeness to God on health, and belief that illness is a test from God, as well as mental health beliefs and practices which incorporates Jinn possession and Qur'an verse reading as first line treatment are indicators of how religion has the most influence on health beliefs, values, and practices in the Somali community.

Theme 1: Significant Influences of Religion on Health and Care

All informants identified the importance of their religion in their health beliefs and practices, and indicated the need for this to be incorporated into their treatment plan

as well. One informant stated, "Religion is a huge part of the Somali community. We are Muslims. In general, most Somalis believe that if someone is sick, they don't need to go to the doctor. They need to read the Qur'an, then they will heal." Another informant stated, "As far as healthcare, people go to religion and the holy Qur'an first. Even here in America this happens. A woman I knew told her family that she was hearing voices but they didn't want to take her to the hospital because they believed that the hospital would cause more problems so they kept her at home, had an Imam read the Qur'an, but she tried to kill herself. Families don't always know what to do."

Considering this importance of religion and incorporating time for prayer, providing access to the Qur'an, assessing for concerns about Jinn possession, and making available same gender care givers were identified as ways to help build trust and respect so that education about mental health and available care that is congruent with religious beliefs and practices can be provided.

As was identified in the literature by Boynton, Bentley, Jackson, and Gibbs (2010), the key informants confirmed that in the Somali culture, a person is either "crazy" or not. There are a lot of misperceptions and stigmas associated with mental illness in the culture, and many informants used the word "taboo" when referring to mental health issues. Most of the informants were surprised when they learned that Somali people were hospitalized for mental health issues. The key informants were able to identify that mental illness is a serious issue in the population, but reported that no one wants to admit this. This is especially true in the older population. It may be difficult for a Somali person to admit to suffering from psychiatric symptoms because of the stigma associated with it in the community. The key informants also pointed out that it can be viewed as

disrespectful to ask about suicidal thoughts because it is prohibited to take your life in the Islam religion.

Theme 2: Tribe Connectedness, Cultural History and Khat Usage are Significant in Health Care Access and Treatment

Informants readily identified cultural care issues such as khat usage, history of trauma, communication barriers, and tribe/family involvement as influencing their healthcare access and experiences. One informant said this about family members staying the night with patients in the hospital, "this is a norm and it feels like if you left a female in the hospital by themselves, the family is going to get judged, you know what I mean, so, it's like your mother, or somebody, anybody from your tribe has to be there or they will talk about how their daughter's in the hospital and no one's there. So, I saw my family, not my family, but my family-in-law going through that part, so like the nurses getting educated about it and letting them know that this is normal in the Somali culture and if you guys could at least just respect that. If they have visitors coming on through, you know what I mean, 'cuz I see that where they get really irritated, like really irritated and they are like, why are they here, but that's their family member. Whether it's mentally or physically, they have to come there." Accounting for cultural care issues and allowing extended family visits, assuring interpreters are available, and assessing khat usage and history of trauma were identified as ways to improve healthcare outcomes.

Key informants confirmed the value of respect in the Somali community. Respecting others and treating them with dignity is viewed as an important value, as well as helping those less fortunate. The value of respect presented again in data obtained from interview questions seeking information on important nurse qualities as informants

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identified being able to respect a nurse by trusting what she said was the most important quality. However, key informants also endorsed data indicating that Somali people will trust a Somali staff member more than a non-Somali staff person. Key informants also confirmed that women are the ones designated to show the care and do so by going to an ill person's house or the hospital and staying with them, assisting others in need and bringing them food, and reading the Qur'an to anyone suffering. Men can also be caring but show care more by being strong and protective. All informants stressed that men should have a male healthcare providers and nurses if possible, and females should have female healthcare providers and nurses if possible. The key informants also reinforced that men in general don't talk about things or show emotions because this is viewed as a weakness, but women are pretty open about issues. They identified that it is a male-dominated society, and identified that men typically respect other men more than women. Many of the key informants added that the gender differences are changing and are becoming less distinct here in the United States.

Key Informant Confirmability

Key informants confirmed and expanded on information gathered from the general informant interviews when they were interviewed for a second time. They concurred that Minnesota was home to so many Somali immigrants because of the large, supportive Somali community and good social service system in Minnesota. They identified that this community's leaders include the religious leaders, the Imams (who are the leaders of the Mosques) and the Sheikhs (who are similar to Imams and referred to as scholars), and the Elders who make any needed community decisions, settle disputes between members, and settle disagreements between tribes/clans members. It is

imperative when conducting any research with the Somali population, to consult with the elders in the community first. Tribe membership was dismissed as an issue in the healthcare arena, but sometimes it can be in the Somali community. Although tribe membership is supposed to be positive and a way to connect to ancestry, it can be quite negative at times and lead to fighting and community problems.

Key informants confirmed that the community uses exercise, healthy eating, reading verses from the Qur'an, praying, and spending time with family and friends to stay healthy. Wellbeing was defined as being healthy and able to work and do what one needs to do to function in life. Being healthy and feeling well is closely tied with religion and being close to God through prayer and Qur'an reading. They also all emphasized that the first line of treatment for any illness involves reading verses from the Qur'an. They asserted that religion tops everything else in their community and that everything circles back around to include their religious beliefs and practices, although they identified that this would be true of all people who practiced the Islam religion. Their religion influences the food they eat (garlic, honey, and "black seeds" are viewed as healthy as the Prophet encouraged their use), what they do with their time during the day, how they view and interact with other people, and how they view health and illness. Sickness is viewed as a test from God, and although it is acceptable to seek medical care when needed, a person cannot be healed unless it is God's will and they have faith that it will happen. In general, Somali people do not like to take medications either, and to take medications when they are not experiencing symptoms is virtually unintelligible in this population.

A couple concepts explored in data collection that were novel to the researcher were Jinn possession, "black magic", "evil eye", and khat usage. Key informants confirmed that all Muslims believe that Jinn are beings that were created by God, just as humans were, but they are at a lower status than humans, can be good or bad, can't be seen by humans, but can possess them. A person that is possessed by a Jinni will act wildly, scream, hallucinate, and talk in the voice of the Jinni. Specially trained religious leaders recite verses of the Quran "on the person", will talk to the Jinni and find out why they possessed the person, and then get them to leave. Reading verses from the Qur'an hurts Jinn, but they may not leave right away and the religious leaders may need to strike the person as well, although this hurts the Jinni and not the person. People can also be possessed by another person's soul as well, through "black magic" and "evil eye", although it is against the Islam religion to do so. If symptoms continue after treatment for Jinn possession, "black magic" possession, or "evil eye", then the person likely has a mental health issue and they will be encouraged by others to seek medical treatment. Another concept affecting mental health that is present in the Somali culture is khat usage. Khat is from a tree in East Africa, is chewed or put under the tongue, and is used mostly by men in certain social settings. It is a stimulant and when people use it, they will stay awake for days, traditionally to talk about politics and social issues. This can cause problems with employment, families, and may induce or exacerbate mental health symptoms and disorders.

Action-Decision Care Modes

Culture care preservation and-or maintenance, culture care accommodation and-or negotiation, and culture care repatterning and-or restructuring are the three action-

decision care modes that are unique to the culture care theory and important because they are essential for caring and are to be used with specific research care date discovered from the theory (Leininger and McFarland, 2006, Chapter 1). Reading of the Qur'an is the first remedy that a Somali immigrant seeks when they begin suffering, and it is of great benefit and value for the culture (culture care preservation and-or maintenance). Since reading of the Qur'an causes no harm and improves outcomes, it should be included in the requesting Somali immigrants plan of care (culture care accommodation and-or negotiation). A provider may need to work with a Somali patient in understanding the importance of treatments outside of reading the Qur'an and negotiate other treatments for better outcomes, as well as negotiate discontinuation of khat usage for improved mental health outcomes (culture care repatterning and-or restructuring). The large Minnesota city that served as the setting for this study has community centers and clinics with health promotion and prevention programs to assist the Somali immigrants with service needs.

Discussion

The major assumptions of this student as adapted from the assumptions of the Culture Care Theory (Leininger and McFarland, 2002) were supported in this study. The Somali culture was discovered to have generic and professional care that can be used to provide culturally congruent care practices to this population. The meanings and experiences of mental health care became understandable when viewed within the cultural context of Somali immigrants. Mental health care meanings and experiences within the Somali cultural context contributed to nursing knowledge and practice. The

discovered culturally congruent mental health care practices will assure appropriate, meaningful and competent care for Somali immigrants.

As specified by the U.S. Department of State (2011), and confirmed by the informant interviews, Somalis share a common language, culture, and religious beliefs. These Somali cultural and religious beliefs and practices influence their mental healthcare choices for accessing and accepting care. The informants were able to identify several things that nurses could do to help promote mental health and be supportive to Somali patients. They stressed the importance of allowing for family and tribe involvement, and suggested asking patients' family and tribe members about changes in behavior because some behaviors that appear odd to healthcare providers may be normal for the culture or that specific person.

As indicated by Brons (2001), one of the other ways that a Somali person identifies themselves is by their religion. Pyke, Morris, Rabin, and Sabriye (2001) emphasize the importance of religion in the lives of Somali people and assert that this must be considered in developing a treatment plan. The key informants confirmed this and indicated that it would be important to allow Somali patients time for praying, meditating, and reading the Qur'an. They indicated that it would be helpful to bring in religious leaders when possible as well. Scuglik, Alarcón, Lapeyre, Williams, and Logan (2007) indicated that Somali people rarely acknowledge mental illness, and the informants concurred with this and confirmed that there is a stigma in the Somali community associated with mental health issues. The informants also stressed the desire of most Somali people to avoid taking medications, and suggested that to increase

medication adherence, education about the medications with an explanation of the reason they are necessary in understandable terms, would decrease fear and improve adherence.

Brons (2001) acknowledged the trauma that the Somali people have been through in their war torn county. Many informant interviews, as well as observations made by the researcher, made the trauma that many Somali immigrants have been through quite tangible. The key informants, as well as a community provider the researcher interviewed that regularly cares for mentally ill Somali clients, advised that healthcare staff and providers realize that they have been through serious trauma. Also, according to the results of the study conducted by Scuglik, Alarcón, Lapeyre, Williams, and Logan (2007), language barriers and cultural misperceptions were identified as the most frequent obstacles. The informants indicated these were issues as well and recommend interpreters be readily available to Somali patients seeking mental health care.

Limitations

The study has a recognizable limitation. Communication problems can occur when working with informants that identify their primary language as one other than that of the researcher. The use of interpreters can lead to communication problems as well, especially if they do not have a good understanding of the topic area. Fortunately in this study, both interpreters used were also psychiatric mental health nurses and have a good understanding of the topic area. There could be communication problems if the interpreters do not understand mental health terms.

Conclusion

This study discovered mental health care meanings, beliefs, and practices of Somali immigrants living in a Minnesota community with a high Somali population as

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they are influenced by shared cultural values, beliefs and practices. The informants revealed unknown dimensions related to mental health care perceptions, meanings, beliefs, and practices. This study was conceptualized within the framework of Leininger's Culture Care Theory and the ethnonursing method guided the researcher to obtain valid and rich data. The findings of this study added to transcultural nursing knowledge related to the Somali culture and the mental health meanings of care for Somali immigrants. It had also contributed to nursing and provider mental health care decisions and actions that are more culturally congruent. It also demonstrated that more research studies are needed in various immigrant communities and to continue to explore concepts like Jinn so that culturally congruent mental health care practices for this and other population can be provided.

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Table 1. Informant Demographics

Age by Decade	Number
20's	17
30's	6
40's	4
50's	2
60's	1
Gender	
Male	8
Female	22
Religion	
Islam/Muslim	30
Primary Language	
Somali	30
Secondary Languages	
English	30
Arabic	11
Swalhili	10
Marital Status	
Married	16
Single	12
Divorced	1
Widowed	1
Number of People in the Home	
1-2	2
3-4	23
5-6	5
Adults	
1-2	24
3-4	5
5-6	1
Children	
0-1	14
2-3	15
4-5	1
Years Living in United States	
0-5	0
6-10	9
11-15	21
Years Living in Minnesota	
0-5	5
6-10	7
11-15	18

Education

None identified	2
Gradeschool	1
Middleschool	3
HighSchool	8
College Educated	16

Table 2. Summary of Findings (N = 30)

Identified Categories
Mental Health Care
"Crazy" or Not
Religious Influences on Care Practices
Jinn Possession
Male Gender Care Differences
Female Gender Care Differences
Appreciate Care America and Minnesota
Care and Support in Mall Settings
Communication Issues in Health Care
Well Being Descriptions
Care Descriptions
Generation Care Differences and Elders
Cultural Care Issues
Traditional Health Remedies
Family and Tribe Involvement in Health and Care
Evil Eye Causing Illness
Trauma Effects on Health Care
Care of Children
Khat Effects on Health and Community
Respect in Care
Trust and Taboo in Mental Health

Patterns
Mental Health Care Beliefs and Care Practices
Religion Importance and Influence on Health and Care
Gender Differences and Roles Influence Care
Appreciate Care in America and Minnesota
Cultural Communication Issues
Cultural Well Being
Cultural Care
Elders and Generation Differences in Health Care
Cultural Care Issues

Major Themes
Significant Influences of Religion on Health and Care
Tribe Connectedness, Cultural History and Khat Usage are Significant in
Health Care Access and Treatment

Data Organization

Major Themes
1) Significant Influences of Religion on Health and Care
   Patterns
   Mental Health Care Beliefs and Care Practices
      Identified Categories

Mental Health Care

"Crazy" or Not

Religion Importance and Influence on Health and Care

Identified Categories

Religious Influences on Care Practices

Jinn Possession

Gender Differences and Roles Influence Care

Identified Categories

Male Care Gender Differences

Female Care Gender Differences

2) Tribe Connectedness, Cultural History and Khat Usage are Significant in Health Care Access and Treatment

Appreciate Care in America and Minnesota

Identified Categories

Appreciate Care in America and Minnesota

Care and Support in Mall Settings

Cultural Communication Issues

Identified Categories

Communication Issues in Health Care

Cultural Well Being

Identified Categories

Well Being Descriptions

Cultural Care

Identified Categories

Care Descriptions

Elders and Generation Differences in Health Care

Identified Categories

Generation Care Differences and Elders

Cultural Care Issues

Identified Categories

Cultural Care Issues

Traditional Health Remedies

Family and Tribe Involvement in Health and Care

Evil Eye Causing Illness

Trauma Effects on Health Care

Care of Children

Khat Effects on Health and Community

Respect in Care

Trust and Taboo in Mental Health

Exemplars

Major Theme	Pattern	Exemplar
Significant Influence of Religion on Health and Care	Mental Health Care Beliefs and Care Practices	"I mean for us I guess the first of line of treatment, a lot of people go toward like the religion, especially for like mental health, you know, because of the Jinn, the first source of treatment would be like the holy, the Qur'an."
Significant Influence of Religion on Health and Care	Religion Importance and Influence on Health and Care	"Religion is a huge part of the Somali community. I believe that 99% of the Somali community are Muslims. Um, and they believe, we believe that if someone is sick, we don't need to go to the doctor. And if someone, if we read Qur'an to that person, then they will heal.
Tribe Connectedness, Cultural History, and Khat Usage are Significant	Cultural Communication Issues	"I think it is more of a language barrier. It's hard for them, ya, they could have a translator, but they may not be able to get out everything they may want or that person may not, you know. It can be frustrating. I've heard multiple people complain about their translators."
Significant Influence of Religion on Health and Care	Gender Differences and Roles Influence Care	"We're not suppose to have too much of, like, interaction between male and female, our religion, our culture, it doesn't like too much, like, mixing of the sexes."
Tribe Connectedness, Cultural History, and Khat Usage are Significant	Elders and Generation Differences	"There are misperceptions about, you know, mental health in the older population, and about, you know, medications, and a lot of people don't understand that."

Tribe Connectedness, Cultural History, and Khat Usage are Significant	Appreciate Care in American and Minnesota	"Absolutely, absolutely, most get what they need, a lot of Somali people are not fortunate, they are not educated, so they have medical assistance, food assistance, that's why they love America and that's why they love Minnesota."
Tribe Connectedness, Cultural History, and Khat Usage are Significant	Cultural Care	"The woman is supposed to be showing the caring part, not the husband or the brother. Even if they are going through a divorce, you are not going to see them, you know, like cry, or show any sign of emotion. I feel like that is the one thing that is missing in our Somali culture, seriously. They might be feeling it, but they won't be showing it at all whatsoever, you move on basically."
Tribe Connectedness, Cultural History, and Khat Usage are Significant	Cultural Care Issues	"They do not like to talk about the trauma they have been through and will deny they have been harmed. Ask if their house was attacked during the war. If yes, who was killed in the attack? Who was injured? Were the women attacked?
Tribe Connectedness, Cultural History, and Khat Usage are Significant	Cultural Wellbeing	"Wellbeing means to be physically and emotionally well, although in my culture, wellbeing means to be able to complete you duties, you know, going to work, doing their own things, taking care of themself."

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Appendix A

Fieldwork as a Way of Knowing: An Italian Immersion Experience Manuscript

Abstract

To gain real world experience in a different culture and to understand its health system, the researchers immersed themselves into the Italian culture for one week. This paper demonstrates the use of fieldwork as a valuable tool early in the research process. The researchers used the Sunrise Enabler to view and understand culture, took field notes, and used interpretation consistent with fieldwork. This resulted in the following common and holistic themes: 1) sense of family closeness and value of kinship, 2) religious influence, 3) health care as a right, and 4) vulnerability in a new environment through the lens of the observers. Collective interpretation and literature support each theme. Following this experience, the researchers had an increased understanding of Roman Italian values, beliefs, customs and a new found appreciation and interest in the inclusion of immersion prior to any formal research.

Key words: culture, transcultural, ethnonursing, fieldwork, research, topic development

Introduction

Health care professionals around the globe provide care to people of diverse cultures in various settings. Regardless of the type of health care system available, clients, including immigrants, refugees and tourists, have the right to the available health care system and to "health care personnel that are respectful of their personal beliefs, values, and health care practices" (Purnell & Paulanka, 2008, p. 1). Culturally competent health care staff should be a fundamental aspect of any health care system. This could lead to client**s'** satisfaction with health care and reduce possible health disparities (Purnell & Paulanka, 2008). According to the World Health Organization (WHO) (2012), health care products and services, including health care facilities, must be respectful of culture. To provide culturally competent health care, health care professionals must have and use knowledge that is congruent with the client's cultural beliefs and values.

In an attempt to gain further understanding of transcultural nursing and health care, the diverse group of nine researchers (see table 1) immersed themselves in the Italian culture and health care system in Rome, Italy. They used the ethnographic data collection strategy of fieldwork focusing on observation and interpretation. Fieldwork and the subsequent field notes provided a rich description of activities and way of knowing the phenomenon of interest, the Italian culture of Rome, and the Roman Italian health care system. Concurrently, the researchers analyzed the field-work including observations and interpretations for theme development. Intercoder agreement determined reliability of this fieldwork. Additionally, the researchers used Leininger's Theory of Culture Care Diversity and Universality as a theoritical guide during the immersion experience. (Leininger & McFarland, 2006).

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Purpose

The purpose of this paper is to demonstrate the use of fieldwork through cultural immersion as a valuable tool early in the research process. Immersion in the topic of interest, tied with the craft of taking field notes and interpreting those note**s**, aids the researcher in her or his quest to generate interest and develop ideas about a researchable topic. This process develops a broader understanding of the phenomena, uncovers multiple researchable issues, and refines conceptualization of research problems.

Background

The nurse scientist seeks to contribute new knowledge to the profession through careful systematic research of a topic of interest. The research continuum spans from topic identification to the terminal goal of new knowledge dissemination. Early in the research process, the nurse scientist seeks an intimate and personal understanding of the topic and problem. Personal interest, clinical experience, the scientific literature, social issues, and theories stimulate a nurse researcher's interests (Polit & Beck, 2008). This paper expands this formulation to include fieldwork as a means of better understanding a research topic. Understanding phenomena through cultural immersion generates personal interest and engagement in the subject. Further, fieldwork is useful to a researcher once he or she identifies a topic. The fieldwork provides a means to approach phenomena inductively and through whole knowing essential to disciplines like nursing, which often focus on social and human conditions. In qualitative research, fieldwork is used to explore and understand the meanings individuals or groups ascribe to a social or human problem (Creswell, 2009). The researcher acquires inductive knowledge about phenomena of interest through contact with and immersion in the phenomena. Fieldwork

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and the related use of field notes by the researcher contribute to the development of personal knowledge of the phenomena. The authors participated in an immersion experience in Rome, Italy to gain this type of whole knowing about their interest areas—Italian culture, indigenous healthcare practices and beliefs, vulnerability, and the experience of being the cultural "other." The immersion provided them an opportunity to examine the Italian healthcare system through a holistic and personal method of inquiry.

While not an ethnography, this project used the ethnographer's skills of fieldwork and field notes as a beginning process of inquiry. Ethnographers utilize field notes to gain an inclusive and extensive picture of the culture of a group under study (Munhall, 2007). Writing field notes involves processes that fit with the descriptions of methods for capturing personal knowledge. The authors maintained field notes throughout their immersion experience. These notes documented the individual's observations and reflections. Each individual made notes of their experience and interactions. Similarities and differences between participant**s'** observations exist based on prior knowledge, interest, context, and perspective. These observations and choices are informed by knowledge of the target group, purpose, and phenomena of interest. The goal is to provide rich description of experiences. The field researcher seeks to gain an understanding of cultural knowledge through observation and interaction (Munhall, 2007). The authors recorded their encounters as descriptive depictions of events, encounters, and interactions.

The field researcher is encouraged to put aside or bracket preconceptions and make objective and systematic observations (Munhall, 2007); the personal thoughts and insights of the researcher are noted as part of the experience of observations. The choices

and decisions the researchers made in the process of observation, along with their preconceptions, expectations, and bias, are documented, and compartmentalized. These reflections and analyses are part of writing field notes and facilitate knowledge development or idea generation. Moch (1990) encourages the development of personal knowledge through "discovery of self-and-other arrived at through reflection, synthesis of perceptions, and connecting with what is known" (p. 155). This is achieved through encounters with people and events. The authors strived to eliminate preconceived notions and cultivate "receptive attending," a deliberate disposition of openness, purposeful awareness, and an inquisitive frame of mind (Moch, 1990).

Immersion in the problem through fieldwork and the process of writing field notes helps the researcher to "make explicit what is intuitively understood about what is going on in context" (Munhall, 2007, p. 301), a process similar to the context of wholeness and encountering found in personal knowing as described by Moch (1990). The idea of being situated in the context of events is central to understanding the meaning attributed to the activities and events. The researcher seeks to discern local knowledge and meanings by "looking for the perspectives and concerns embedded and expressed in naturally occurring interactions (Emerson, Fretz, & Shaw, 1995, p. 28). The rich whole knowing that develops through the process of immersion and the subsequent writing and analyzing field notes, leads to new perspectives and understandings about the phenomena. This knowing is consistent with the authors' experience in Italy. The authors discovered both knowing about the phenomena of interest and personal knowing through reflection and analysis as evidenced in the analysis of field notes.

To prepare for the experience, the researchers participated in exercises to improve their observation and field note taking skills, as well as advance their skills in working with qualitative data. The researchers made purposeful observations on at least 3 different occasions in their own communities, recorded field notes, and then imported and managed the notes in Nvivo9 data manager. Each researcher worked on coding the data and observing for emerging categories and themes collaboratively with an experienced qualitative researcher. They also advanced their knowledge of Leininger's four phases of data analysis and worked with a qualitative researcher in utilizing a modified version of this method in viewing the data they collected during the exercises. In addition, the researchers read about Italian and Roman culture in preparation for the travel.

Theoretical Guide

Leininger's Theory of Culture Care Diversity and Universality was used as a guide during the authors' immersion experience in Italy, as it promotes a unique view of the Italian culture. According to Leininger's theory, all cultures of the world possess indigenous health care beliefs and practices (Leininger & McFarland, 2006), and this would include the influences of the Roman culture on contemporary Italian culture. Although fieldwork through cultural immersion can be seen as the beginning of inquiry, aspects of the Sunrise Enabler provided a foundation that guided the researchers in the understanding of culture during the fieldwork immersion experience.

Sunrise Enabler as a Model

Leininger developed the Sunrise Enabler as a cognitive research guide to assist researchers in pulling out culture care phenomena from a holistic perspective of multiple factors that have the potential to influence the care and well-being of people (Leininger &

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McFarland, 2002). However, for the purposes of this fieldwork immersion experience, the researchers used the Sunrise Enabler as a pictorial model to help them understand the components of a culture as defined by Leininger and McFarland. Using the Sunrise Enabler as a pictorial model enabled the researchers to view the Italian culture through those lenses, as it connected their observed reality to the theory. The dimensions of the Sunrise Enabler include technological factors, educational factors, religious and philosophical factors, economic factors, political and legal factors, and kinship and social factors, as well as cultural values, beliefs, and life ways. Although the researchers did not explore all of these dimensions, the detailed holistic approach of using the Sunrise Enabler as a pictorial model assisted them in gaining increased understanding the Roman Italian culture. The researchers visited the Vatican and the Jewish Quarter (religious and philosophical factors ray component), viewed hospital equipment and a laboratory (technology factors ray component), observed families socializing in parks and restaurants (kinship and social factors ray component), and rode the local buses and the metro while engaging with Roman people in the surrounding environment (cultural values, beliefs, and life ways ray component).

Interpreting and Categorizing Field Note Data

A two-step process was utilized to interpret and categorize the immersion experience field note data. During the first step of the process, each researcher kept and interpreted individual field notes throughout and immediately following the week-long immersion experience. The group of researchers then came together, categorized the collection of interpretations, and identified common categories through their own lens and with the guidance of the sunrise enabler model. During the second step of the

process, they further analyzed the categories into common and holistic themes. From these themes, the researchers were able to identify potential nursing opportunities and ideas for future research.

Fieldwork

Hoping to glean insight into the perceptions and experiences as foreigners, the researchers observed the Roman Italian health care system, and ultimately began to make comparisons to the United States health care system, as this is the health care system that is familiar to the researchers. Additionally, the researchers hoped to experience what it was like to be in a non-English speaking environment and to experience a different culture. The Sunrise Enabler guided the researchers' attention to areas of interest upon which to focus during the observations, but allowed for opportunities to be open to all observations. The focus included the aforementioned technological factors, educational factors, religious and philosophical factors, political and legal factors, social factors, cultural values, and life ways. In order to fully immerse into the Italian culture, understand the context of the culture, and gain an appreciation of the healthcare system from the etic perspective, observations were made in the community, shopping areas, the metro, the bus, restaurants, one private hospital, and one public hospital.

The researchers began the observations from the moment they arrived in Rome and were immediately aware of a shift from their normal habitat and worldview, which occurred throughout the immersion into the culture. Some observers noticed the differences from their normal habitat in the destination airport; others noticed a difference while checking into their rooms or boarding the public transportation.

The following section will provide a summary of the common categories researchers identified from their fieldwork interpretations and will conclude with the identification and discussion of common and holistic themes. Recognition of themes led to the identification of researchable phenomena and questions for inquiry. The authors reviewed the literature for support of the common categories and themes, and this section also presents pertinent findings.

Common Categories

As the researchers analyzed their field notes to discover common themes, the clustered, common observations and behaviors were translated into common categories. The common categories that emerged from this process were verbal and written language, personal body space, personal safety, wellness behaviors, ancient and modern Roman culture, public and private hospitals, and healthcare professionals.

Verbal and Written Language

Verbal and written language differences create difficulties in expressing and thus accessing one's needs and can lead to anxiety, fear, and uncertainty. The researchers identified a constant need for heightened alertness when reading maps and signage on public transportation and communicating. They also realized increased acuity and attention to listening and hearing an unfamiliar spoken language and perceived vulnerability when they encountered difficulties during communication. In the United States, an inability to adequately communicate in English is viewed as an obstacle to health care (Clemans-Cope & Kenney, 2007; Hampers, Cha, Gutglass, Binns, & Krug, 1999; Mattox, 2010) and is a significant factor in immigrant vulnerability. Kim, Worley, Allen et al. (2011) and Shi, Lebrun, and Tsai (2009) found fewer physician visits, less

preventative care, and a lack of consistent service settings were associated with limited proficiency in English.

When the researchers attempted to communicate in the Italian language, a feeling of acceptance and respect for the people and Italian culture replaced the feeling of vulnerability. The native people seemed to appreciate their attempt to speak Italian, resulting in increased patience during the encounter. The researchers perceived relief when signage was printed in both Italian and English.

Personal Body Space

Researchers identified a feeling of intrusion into their personal body space while walking, standing in lines, or riding public transportation. In crowded places, it was not unusual for people to be touching due to lack of space. An understanding of the concept of personal space for the Italians versus Americans was needed to avoid misunderstandings.

Personal Safety

Safety was a concern noted by the observers, especially when motorized vehicles and pedestrians came into close proximity. Many cars and motorcycles speed along the streets in Rome with little regard to safety. Italy has more traffic deaths than most of Europe, most related to scooters, a common European mode of transportation (U.S. Department of State, 2011). Pedestrian fatalities are common in Italy (Australian Department of Foreign Affairs and Trade, 2011), underscoring the need for extra caution when crossing roads by foot. Squires (2008) cites congestion; small, winding roads; and speed as the primary causes of the great number of accidents. The observers expected that stepping into the crosswalk would result in the vehicles yielding to the walker, but

frequently the walker needed to step back to avoid being run over. Once the researchers became acclimated to this procedure, they realized a degree of self-confidence and comfort.

The concern for traffic rules, diet, and car safety-seat use that was observed in Rome spurred the researchers to consider how immigrants and refugees might feel when they come to the United States. As visitors to another country, the researchers may have felt insecure, but the influences causing this insecurity are normal to the native Italians. In comparison, immigrants and refugees might feel the same when they arrive in the United States. From the etic perspective, things that one takes for granted can become real concerns for those unaccustomed to them.

Wellness Behaviors

The prevention of disease and promotion of healthy behavior choices is a focus in the United States Health Care system. The prevention of smoking or smoking cessation and dietary control of sodium intake are primary focuses of wellness behaviors. In Rome, the researchers frequently observed high numbers of people smoking in public areas such as restaurants, bus and metro stops, plazas and while walking. They also observed high-sodium content foods on restaurant menus and in the grocery store. The smoking and dietary concerns are healthcare issues observed by the researchers to be similar to those in the United States. It was difficult to confirm the specific nationality of the observed people engaged in these behaviors, so there is a need for additional fieldwork to confirm and validate these observations.

Ancient and Modern Roman Culture

Rome is connected to its past through the architecture, art, and lifestyle. Evidence of prior civilizations is continually uncovered. Reconstruction on the subway system was delayed, as digging revealed ancient discoveries. One hospital uncovered ruins in the foundation; the excavated area is glass-encased as an exhibit in the basement, demonstrating the contrast between modern medical technology and ancient civilization. The observers noted the nursing director's sense of pride in the exhibit, a sense of being Roman Italian. In another hospital, public spaces contained architectural features, sculpture, and paintings that predate the United States.

In and around the city, they observed apartment-style housing structures and few single family homes, even on the city's outer limits. Some businesses and storefronts appeared to be newer and modern constructions; however, the residential areas appeared to be a mix of much older architecture with newer structures. Many windows had functional shutters and awnings, to allow airflow into the rooms and the researchers observed that air conditioner use was rare. The researchers also noted that, occasionally, an open entryway door revealed an inner courtyard with flower gardens, palm trees, stone fountains, and seating; several opened into gated parking spaces (in a city with limited parking).

With the notable exception of automobiles and the roads, the pace of life in Rome was more relaxed and slower than in the United States. The Roman Italian people spent more time having meals and walking between venues and observed shorter and less frenetic working hours.

The presence of history is inescapable in Rome, and a sense of the decades and centuries is inherent to the environment. Guided tours of ancient sections of the city

explained how one generation or era would incorporate or recycle structures from the preceding era. Symbolism prevailed throughout the city's growth and development from the Roman Empire at its peak, the growth of Papal Rule and Vatican City, the rise of fascism, and modern Rome. During the brief immersion experience, it was difficult to determine how this historical presence fully affects the Roman identity, or how it influences other areas of Italy. Conversely, in spite of this deep pride in their heritage that the researchers observed many Romans expressing, the public is permitted to access many of Rome's ancient treasures.

Public and Private Hospitals

Approximately 90% of the Italian populations are members of the Roman Catholic religion, but only one-third are practicing the religion (Rapid Intelligence, 2011). The Catholic Church is credited with building and administering the hospital systems since ancient times. The Vatican is the major supporter of the Bambini Hospital and supplies the needed funds in the care for sick infants and children. Because of the religious influence, Catholic hospitals maintain the conviction of offering no reproductive sterilizations, birth control, or abortions; however, non-Catholic hospitals can provide these services (Public hospital director of nursing, personal communication, June 20, 2011).

The Italian government has the responsibility to ensure that all Italian citizens receive health care. Health care is an entitlement; the government will ensure care is provided for you. Government hospitals are referred to as public hospitals; private hospitals are available to anyone who has additional insurance or can pay cash for their services. The researchers had the opportunity to visit both a public and a private hospital.

Both facilities offered up-to-date technologies for diagnostic studies, such as radiology, computerized technology scans, sonography, mammography, magnetic resonance imaging, and digital films. The hospitals were equipped with full-service laboratories that offered in-house testing and sent specimens to outside facilities for confirmation when necessary, similar to laboratory services in the United States.

The private and public hospitals each demonstrated both inpatient and outpatient services at their facilities for the researchers' observation, providing interpretation services during the tours. The director of nursing of the public hospital gave a presentation, written in English and created with PowerPoint presentation software. The nurse executive led the presentation, and her verbal and non-verbal communications enhanced the researchers' understanding of the hospital's long history. Activity levels differed between the private and public hospitals. Physicians at the private hospital pointed out that the public hospital was busier because it was free. People choose the private hospital when they do not want to wait for a service like surgery or other admission. Hospital customer service was evident in both institutions.

The researchers' identified the patient and their family to be the most important priority in the administration of health care in Italy. Families were expected to be present during the hospital stay and outpatient services. The design of patient rooms provided for a bed or couch for family members to stay with the patient (the private hospital charged a fee for this service). Family involvement was evident in the public hospital pediatric outpatient area, as a father helped a mother and was present for their infant's examination. Vicarelli and Bronzini (2009) identify the importance of family in Italy and

refer to the Italian welfare system as a "familistic" system, as the family is mainly responsible for taking care of its members in times of illness and vulnerability.

Aesthetically, both hospitals offered windows that opened to allow the fresh air into the space and outdoor terraces for patient and family to sit. The public hospital had an open courtyard with a turtle pond, coy fish, and benches where patients, visitors, and employees could congregate. The influence of the Roman Catholic Religion was present in both hospitals with photographs of religious items, crucifixes in rooms and hallway, and statues of religious icons. The public hospital was more ornate with religious relics dating back hundreds of years.

Healthcare Professionals

Professional nurses in the Italian system are registered nurses and midwives, each having three years of education for a baccalaureate degree; the nurses' uniforms are white. The public and private hospital spokesperson noted that the nursing manager of each unit must have a master's degree, and in the private hospital the managers are distinguished with red epaulettes. There are nurse aides and unit secretaries. There are no advance practice nurses. Physicians are the primary care providers; they complete medical school and enter into specialization similar to American physicians.

During examination of the work area and nursing units, the researchers identified similarities to the nursing units at hospitals in the United States. The nurses' station included a computer, but the staff reported that they did not have an electronic medical record. Medication was stored in a separate room and transported with a medication cart. Hill-Rom® beds were used in the patient rooms. For confidentiality purpose, the researchers did not get to observe nurses or physicians providing care to patients, but the

environment itself appeared to be set up to meet the physical needs of the patient, as well as some of the emotional needs by providing an environment conducive to family presence and involvement.

Common and Holistic Themes

The observers identified seven common categories within their interpretations of their fieldwork in Rome, they include: verbal and written language, personal body space, personal safety, wellness behaviors, ancient and modern Roman culture, public and private hospitals, and health care professionals. Four common and holistic themes resulted from the interpretation and synthesis of these common categories. The common and holistic themes identified are 1) sense of family closeness and value of kinship, 2) religious influence, 3) healthcare as a right, and 4) vulnerability in a new environment through the lens of the observers. Each of the themes identified will be discussed and validated by the field notes from this observation. Themes 1, 2, and 3 are based on the observations and interpretations in the fieldwork and immersion experience of the Italian Roman culture. Theme 4 is based on and related to the insights and reflections of the researchers being in the Italian Roman culture.

Sense of Family Closeness and Value of Kinship

The researchers' fieldwork recognized the need for clear communication for all individuals participating in community experiences and healthcare encounters. Without resources to understand communication, anxiety, fear, and confusion can result. Many of the observers described communication concerns. Observer one wrote, "I guess one of the things that struck me was the fact that I had written a few times that I was frequently not able to tell what nationality a person was until they spoke. If they were quiet and said

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nothing, it was often hard to tell. Also, people frequently begin talking to me in their native language first when I approached them--of course—I am sure I would too." Another observer noted, "From the moment I landed in Rome, I realized that communication would be a problem because I didn't know any Italian. Looking at the signs in the airport, I suddenly knew that English was not the number one priority here. I was in trouble; I could feel my anxiety level growing."

In both hospitals, patients and staff conversed in the hallways at a close interpersonal distance (about 6 inches) and raised their voices only to the point of being heard. One observer noted, "Individuals moving right up to people to speak to them, even as strangers." This observer wrote, "Personal space is very close. They moved very close and spoke softly. I noticed nurses would speak to a patient at their side or directly in front of them. They did not begin speaking from the doorways, as is common in the U.S." In the United States, eighteen inches is considered to be intimately close, with four feet being comfortable for friends (Fong, 2007).

Another observer wrote, "While at the grocery store on my first day in Italy, I got my first taste of the difference in personal space. As I was standing at the grocery store in line to check out, a man came up behind me, and I could literally feel his breath on my neck. I moved up as much as possible while trying not to invade the space of the person in front of me, but he just moved up right along with me. Next, he moved beside me and stood there like he was my husband. It was unnerving. He never said anything to me or looked at me."

In the community, one observer wrote, "I saw families sitting in the park, lying on blankets, eating, talking, and laughing. Families were spending time together. Then on

the next blanket, I saw a couple tenderly touching, smiling, and kissing. The open displays of affection were common." This observer expressed an uncomfortable feeling in the presence of explicit displays of sexuality. The permanence of kinships is greater in Italy than anywhere else in the world and is attributed to the role of family within the life cycle (Sgritta, 1988). Also, a study by Claes (1998) found that Italian teens place family life as central to their self-identity.

When people met on the street, in a restaurant, or in the piazza, they openly greeted each other. Men and women would embrace and kiss each other on both cheeks; first the right side, then the left side. One observer noted, "Even the men kiss and hug."

Several merchants closed their stores during the afternoon hours and returned late in the afternoon. We were told they went home to their families to eat a meal and rest. One observer noted, "Families taking hours to eat meals and drink wine together in the restaurants, laughing and talking closely, spending time with each other. They appeared to be having fun in each other's company, they did not appear rushed, they were close - in each other's personal space." There was a feeling of being in the moment, "Full attention was directed to the other person or people involved in the interaction," wrote one observer, "Time stands still, it doesn't matter – the interaction was the focus, and the people engaged in the relationship."

In summary, the observers had established cultural norms based on living in the United States. Upon entry into the Italian culture, the importance of understanding the language and use of personal space in communication became apparent. The Sense of Family Closeness and Value of Kinship theme is supported by the field note descriptions presented in the earlier section, along with the expressions of personal feelings and

interpretation of family behaviors observed during the fieldwork. Communication involves language and personal space, each being different from the observers' perspectives.

Religious influence

The Roman Catholic Church plays a major role in the religious beliefs of Rome's population. It is the largest sponsor of health care delivery, and this role is viewed as an extension of ministry. Missions and values statements of these healthcare facilities provide the foundation for decisions, thereby providing meaning and identity as a Catholic institution (White & Dandi, 2009). Both the private and public hospitals toured by the researchers had a chapel. One observer noted regarding the public hospital, "There was a shrine of the Blessed Virgin Mary along the one wall, candles available for lighting and praying, no kneeler present, and in addition flowers had been placed at the base of the statue." Another observer noted, "Many religious statues displayed, paintings of religious figures, and crosses hung in patient rooms, hallways, nurses stations, and waiting rooms." Yet another observer noticed "both hospitals had pictures of Pope John Paul prominently displayed in public areas."

These Roman Catholic beliefs affect the healthcare for reproductive services in the country, the director of nursing stating, "No abortions, birth control, or sterilizations are performed here in the Catholic hospital." The people do have an alternative to seek these services in the non-Catholic public hospital or the private hospitals.

Health Care is a Right

The Italian government provides the monetary support to the public healthcare system, and citizens are entitled to the healthcare available in the public hospitals. One

observer noted during the hospital tour that the physician relayed, "In Italy, there is a national health system that is available to all citizens regardless of income. Actually, those who are considered poor may receive services free that would normally require small co-pay. The national health system pays for inpatient services, diagnostic tests, surgeries, medications, doctor visits, and dental services."

Private healthcare and private hospitals are available if citizens elect to self-pay. Healthcare providers in the public and private settings expressed the need to provide the best care for all citizens, saying, "The patient is first of all," and "The public hospital is a busy place. Patients can expect to wait for services unless it is an emergency."

Developed in 1943, Italy has one of the oldest, tax-supported mandatory public healthcare systems in the world and is believed to be one of the most satisfying and advanced (Maio & Manzoli, 2002). National per capita expenditure is approximately half of per capita spending within the United States (Apolone & Lattuada, 2003). With a declining birth rate (1.2 births per woman versus 2.1 in the United States), low infant mortality (5.4 per thousand live births versus 7.2 in the United States), and high life expectancy (82 and 75.8 for women and men respectively versus 79.7 and 73.8 in the United States), Italy is stated to have a very healthy population (Maio & Manzoli).

The Ministry of Health is responsible for national health planning and rules of commercialization of drugs and medical equipment. Its operating principles are human dignity, protection, need, solidarity, equity, effectiveness, and appropriateness. Responsibilities are delegated to 20 regions, with the goal of making them more sensitive to expenditures, efficiency, quality, and satisfaction (Maio & Manzoli, 2002). Local health agencies are responsible for the administration of care, providing three main

facilities for preventative care, hospitals, and districts. Districts provide primary care, ambulatory care, home care, occupational health, health education, disease prevention, pharmacies, family planning, child health, and information services. Criticisms address an inefficient administrative and political structure within the National Health Service (NHS) (Apolone & Lattuada, 2003). A particular issue is long waiting lists for some essential diagnostic tests and screening; citizens address this by utilizing private providers for which they must pay out of pocket. Criticisms and plan adjustments are similar to those occurring within current health care reform in the United States.

The NHS provides primary care, hospital care, rehabilitation, health promotion, and educational activities free of charge. Recently, medical co-pays were eliminated and drug copays introduced to contain costs (Maio & Manzoli, 2002). Complementary health care coverage may be obtained via private individual health insurance plans; however, only 14.8% of Italian citizens subscribe (Apolone & Lattuada, 2003). Private insurance covers what is considered to be nonessential, such as dental care or certain additional in-hospital services.

Vulnerability in a New Environment through the Lenses of the Observers

Researchers identified the theme of Vulnerability in a New Environment through the Lenses of the Observers from the awareness of feeling unsafe and from a concern for behaviors they observed during the fieldwork. Prior to venturing out into Rome, our host cautioned, "Keep your handbags and valuables close to you, especially when traveling on the metro and buses. Pickpockets are watching for opportunities." A travel advisory for Italy was placed by the Australian Department of Foreign Affairs (2011), advising that

the summer is noted for increases in theft, particularly bag snatching, pick pocketing, and vehicle break-ins in larger cities, and on public transportation and around tourist attractions. The researchers observed and experienced these concerns directly. One observer noted, "My handbag is a bit large and therefore unsafe. I look for a place to find something smaller. I walk into a shop and begin to look around. I find a small wallet with a string that I might easily hide." This same observer noted, "We are boarding a very crowded bus. It is difficult to maintain balance. I don't think I've ever seen a bus this full before. It seems such a safety hazard should there be a sudden stop." Another observer was "gestured to by a metro rider to conceal her sunglasses. The older woman actually reached down and spoke in Italian as she showed how easily someone could get the glasses."

Feeling safe and secure requires knowledge of the customary procedures for traveling in the community, and the observers observed and experienced this during the fieldwork. It was imperative that the safety procedures and the system for crosswalks, metro, and bus travel be explicit and understood. The observers identified that they "should have anticipated needing this knowledge prior to traveling, but they did not recognize the need as this was the first travel outside the United States for many of them."

The observers spoke about changes in their perspectives from the beginning to the end of the week's experience. What was once unique and surprising became the expected. The closeness, the hugging and kissing, and the energetic conversations no longer drew attention. The observers became acclimated to the overt behaviors in the culture and began to more deeply focus their attention on the culture.

In summary, the common and holistic themes were derived from the etic data observed during this limited time performing fieldwork. This fieldwork has evidenced the need to delve further into the findings from the Italian culture and the implications they have for the United States in practice and research.

Implications for Future Practice and Research

Findings from this immersion experience will contribute to the discipline of nursing, specifically transcultural nursing practice and research. At the end of the immersion experience, the researchers had an increased understanding of and greater appreciation for the Italian Roman culture and healthcare system. Consideration was given as to how the experience might apply to the United States healthcare system. After reviewing, discussing and analyzing the field notes, common categories, and themes, the researchers discovered several implications for future practice and research. The difficulties encountered while attempting to communicate with the Italians and navigate the metro and bus lines during the immersion experience resulted in the researchers considering how immigrants and refugees might feel when they come to the United States. As visitors, the researchers felt insecure, but for the Italians, it was just everyday life in their normal environment. It is possible to imagine what immigrants and refugees might experience when they arrive in the United States and attempt to negotiate daily living, including meeting their healthcare needs. Based on the researchers' thematic findings, and because they were out of their familiar culture base, the researchers experienced what it was like to be unfamiliar, uncomfortable, and even vulnerable. They discovered that consideration for diverse and non-English speaking populations is something that must be looked at in the United States to reduce healthcare disparities and

to improve the treatment of vulnerable populations. The United States healthcare providers, such as registered nurses, nurse practitioners, and others, may use these findings to reinforce and encourage the use of culturally congruent and holistic care as set forth in nursing standards, especially when providing care to diverse and vulnerable populations.

The immersion experience also piqued the curiosity of the researchers and spurred high energy discussions about new topics of interest. These discussions resulted in the emersion of possible future research topics. With the discovery that religion plays such a large role in the Italian culture, there was interest in investigating how religion, and other possible influences, affects the American healthcare system. The researchers discussed the idea of family closeness and involvement in healthcare, noting the designated hospital room space available for family, and how this involvement might affect care and patient recovery in the two healthcare systems. Future research could identify differences between the American and Italian healthcare systems, focusing on how the Italians provide healthcare for everyone as a right. Future research could also investigate how an immersion experience and field notes can contribute as a valuable tool early in the research process in other countries and areas of interest. The researchers reported feeling different and changed after the experience, which certainly will affect their future clinical and research practices. Consideration should be given to the impact that immersion experiences might have for nursing researchers, practitioners, and students in the areas of research, practice, and academics. As a result of this immersion experience, this team anticipates that future researchers may join in advancing knowledge in transcultural nursing and transcultural care of patients and families globally.

Discussion

This fieldwork experience in Italy offered noteworthy implications to the nursing profession and nursing research inclusive of engagement in an effective research approach, as well as professional and personal development. The cultural encounter is an essential component of understanding another culture (Campinha-Bacote, 2002). This fieldwork provided a rich encounter in the Italian culture from which major themes were identified via field notes: sense of family closeness and value of kinship, religious influence, health care as a right, and vulnerability in a new environment through the lens of the observers. From within each of these themes, areas of interest surfaced related to health care perceptions, patient expectations of nursing, the role of religion in health care, and impact of language issues on the nurse-patient relationship. The benefit of multiple views among researchers performing this fieldwork provided a diversity of inquiry and interpretations of phenomena for study.

There is consensus that conducting research with, instead of on, an individual or group is an appropriate, effective approach (Borbasi, Jackson, & Wilkes, 2005). The fieldwork provided a glimpse of what it would be like to "go native" (Munhall, 2011, p. 285) for a time among the Roman Italian people. Many of the approaches to gaining cultural knowledge are focused on cognitive aspects and fail to account for diversity within groups (Williamson & Harrison, 2010). This fieldwork was a beginning point to explore the Italian culture in general, and as more time was spent in the field, the researchers grew in their understanding of this cultural group as they encountered Italians of all ages and socioeconomic levels.

As a lived experience, the immersion of fieldwork leaves an indelible mark on the nurse researcher as s/he enters the world of the other person, culture, and society, and grows not only on a professional level but also a personal one. The researchers experienced the vulnerability of being a stranger in a new culture with a language they did not speak. The journey of these researchers included reflection on their own culture as another was encountered, creating an opening for growth and understanding unsurpassed in many other research approaches. This passage via fieldwork was at times confronting, intimidating, and humbling, but will no doubt leave a lasting impression.

Conclusion

This paper focused on the use of cultural immersion and fieldwork as a process of inquiry to understand the Italian culture and health care system. As a result of utilizing immersion, field notes were collected and analyzed, which subsequently garnered cultural knowing of the Italian Romans' values and customs. Leininger's Theory of Culture Care Diversity and Universality provided a brief but rich etic description of activities regarding the Italian culture in general as well as the Italian health care system. Four common and holistic themes and aspects of the themes identified in the literature were discussed. Implications for nursing practice, specifically transcultural nursing and nursing research, were identified and discussed. Moreover, this fieldwork through a cultural immersion experience has piqued these researchers to strive to understand the cultural milieu of any individual, family, or community prior to conducting formal research with a particular population. The phenomena of culture, cultural congruence, and cultural diversity are complex issues with multiple opportunities for new knowledge development.

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Table 1. Researcher Diversity Table

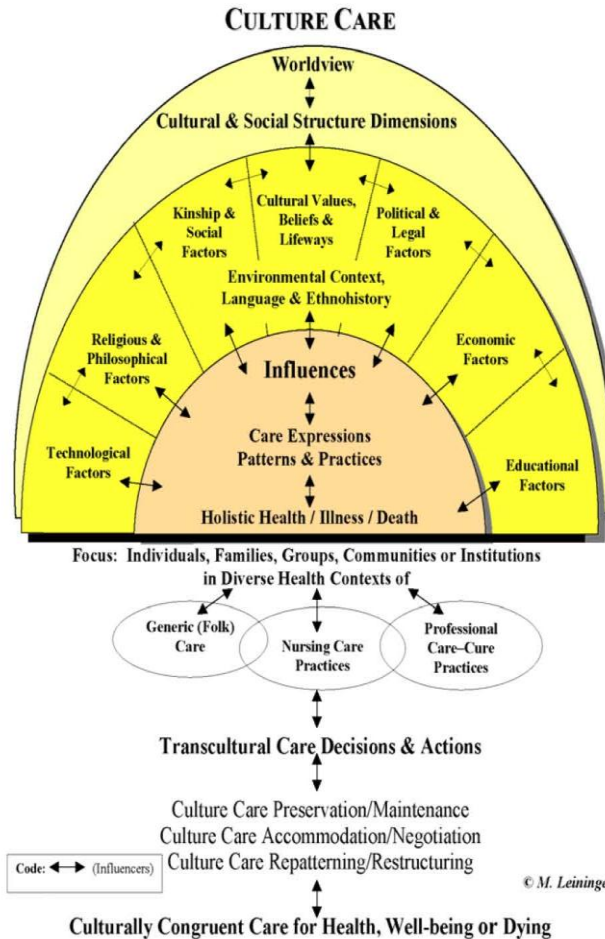| Age Range	38 - 54
Gender	8 Female researchers and 1 male researcher
Education History	Researchers obtained nursing degrees starting in 1977. 8 obtained Bachelors' degrees in Nursing and 1 obtained Bachelors' degree in Interdisciplinary Studies. All researchers obtained Master's degrees in Nursing. 2 researchers have PhD's in nursing and 7 are currently working toward a PhD in Nursing Research.
Current Employment	6 researchers are currently work mainly as faculty members, 1 is a Community College Director, and 2 work mainly as advanced practice nurses (1 is a neonatal NP and 1 is a psychiatric CNS). Of note, the 2 researchers that work mainly in the clinical setting also work as part time as faculty as well.
Area of Residence	The researchers live in a variety of locations in the United States. 5 live in Pennsylvania, 1 in New York, 1 in Florida, 1 in Tennessee, and 1 in Wisconsin. 3 of the researchers live in large metropolitan cities, a couple live in the Suburbs of large cities, and several live in small town and rural areas.
Self- Indentified Cultural Identification	2 identified as Caucasian, 1 as Black, 1 as Irish and German, 1 as Polish, 1 as Jewish, , I as Irish American, and 1 as Italian
Self-Identified Religious Affilation	4 identified as Roman Catholic, 1 as Seventh- Day Adventist, 1 as Episcopalian, 1 as Muslim, 1 as Jewish, 1 as United Church of Christ
History of travel outside the U.S.	The researchers had a variety of experiences traveling outside of the United States.

Appendix B

Sunrise Enabler

Sunrise Enabler

Leininger's Sunrise Enabler to Discover Culture Care

CULTURE CARE

Worldview

Cultural & Social Structure Dimensions

Kinship & Social Factors — Cultural Values, Beliefs & Lifeways — Political & Legal Factors

Environmental Context, Language & Ethnohistory

Religious & Philosophical Factors — Influences — Economic Factors

Care Expressions Patterns & Practices

Technological Factors — Educational Factors

Holistic Health / Illness / Death

Focus: Individuals, Families, Groups, Communities or Institutions in Diverse Health Contexts of

Generic (Folk) Care — Nursing Care Practices — Professional Care–Cure Practices

Transcultural Care Decisions & Actions

Culture Care Preservation/Maintenance
Culture Care Accommodation/Negotiation
Culture Care Repatterning/Restructuring

Code: ◄──► (Influencers)

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Culturally Congruent Care for Health, Well-being or Dying

The Sunrise Enabler is not a model, nor is it a theory. It is an extremely valuable tool to assist the researcher in obtaining a holistic perspective and to discover and assess care phenomena. Since originally being designed in 1970, a few revisions have been made to explicate holistic and social structure factors. The enabler helps to discover actual and potential influencers (not causes) to explain care and well being phenomena as they relate to historical, cultural, religious, and other social structure factors including worldview, economic, environmental, and other major holistic care phenomena. The interrelationship of these diverse factors provides valuable data and helps to explain and understand the informant responses from a holistic perspective.

Appendix C

The O-P-R Enabler

Leininger's Ethnonursing Observation-Participation-Reflection Enabler				
Phases	1	2	3	4
Focus	Primarily Observation and Active Listening (no active participation)	Primarily Observation with Limited Participation	Primarily Participation with Continued Observations	Primarily Reflection and Reconfirmation of Findings with Informants

Appendix D

The S-F Enabler

Leininger's Stranger to Trusted Friend Enabler Guide

The purpose of the enabler is to facilitate the researcher (or clinician) to move from mainly a trusted stranger to a trusted friend in order to obtain authentic, credible and dependable data (or establish favorable relationships as a clinician). The user assesses him or herself by reflecting on the indicators has he/she moves from stranger to friend.

(Largely etic or outsider's views) Informant(s) or people are:	Date Noted	(Largely emic or insider's view) Informant(s) or people are:	Date Noted
1. Active to protect self and others. They are "gate keepers" and guard against outside intrusions. Suspicious and questioning.		1. Less active to protect self. More trusting of researchers with "gate keeping" down or less. Less suspicious and less questioning of researcher.	
2. Actively watch and are attentive to what the researcher does and says. Limited signs of trusting the researcher or stranger.		2. Less watchful of the researcher's words and actions. More signs of trusting and accepting a new friend	
3. Skeptical about the researcher's motives and work. May question how findings will be used by the researcher or stranger.		3. Less questioning of the researcher's motives, work and behavior. Signs of working with and helping the researcher as a friend.	
4. Reluctant to share cultural secrets and views as private knowledge. Protective of local lifeways, values and beliefs. Dislikes probing by the researcher or stranger.		4. Willing to share cultural secrets and private world information and experiences. Offers most local views, values and interpretations spontaneously or without probes.	
5. Uncomfortable with becoming a friend or confiding in a stranger. May come late, be absent and withdraw at times from the researcher.		5. Signs of being comfortable and enjoying friends and a sharing relationship. Gives presence, on time, and gives evidence of being a genuine friend.	
6. Tends to offer inaccurate data. Modifies "truths" to protect self, family, community, and cultural lifeways. Emic values, beliefs, and practices are not shared spontaneously.		6. Wants research "truths" to be accurate regarding beliefs, people, values and lifeways. Explains and interprets emic ideas so the researcher has accurate data.	

This information has been used since 1959 by Dr. Leininger
Adapted from Culture Care Diversity and Universality: A Theory for Nursing by M. Leininger, 1991. New York: National League for Nursing. Reprinted by permission.

Appendix E

Interview Guide including Demographic Form

Demographic Form

Age:

Gender:

Religion:

Education:

Employment info:

Marital status:

Years living in the United States?

Years living in the Minneapolis area?

What type of home do you live in, i.e. an apartment?

Number of people living in home:

Adults:
Children:

What language is most commonly spoken in your home?

What other languages do you speak?

Demographic Form in Somali
Xaaladda Dadka

Da'da:

Jinsiga:

Diinta:

Heerka Waxbarasho:

Shaqadaada:

Xaaladdaada Guur:

Inta Sano oo aad ku nooleyd Maraykan?

Inta sano oo aad ku noolayd Minneapolis?

Nooca Guri ga aad ku nooshahay ?

Inta qof oo ku nool guriga:

Inta qaan gaar ah :
Inta Carruur ah :

Luuqaddee gurigaaga badanaa looga hadlaa?

Luuqadaha kale oo aad ku hadashaan?

Interview Guide Utilizing Leininger's Ethnonursing Research Design

I. Introduction

The purpose of this study with interviews and observations is to learn from you about your life ways in order to plan for and improve mental health care for Somali people. I would like to start our interview by having you describe yourself and then I will talk to you about other aspects of care.

II. Ethnodemographics

1. Tell me about yourself and your family.
2. What is your Age/Sex, Birthplace, Marital status, Occupation, Education, Income, and Religion?
3. How many children have you (your wife) given birth to? Are they all alive and living in the Minnesota?
4. Who lives with you in your household most of the time?
5. Can you tell me what it is like living in the Minnesota?

III. Cultural Values, Beliefs, Life ways

As a nurse, I am interested in your cultural values and way of living in order to be able to plan healthcare for Somalis.

1. Can you tell me about your culture? What is it like to be Somali?
2. What does well-being mean to you?

IV. Worldview/Spiritual/Religion

I would like to learn more about your religious beliefs and practice and especially as they relate to your general wellness and/or health.

1. Tell me about food that you are required to eat? Are there foods you avoid?
2. What foods are avoided that are NOT related to spiritual or religious reasons?
3. Do you observe religious customs or holidays? If yes, which ones and what is the significance?
4. What values and beliefs related to your culture are most important to you and to pass on to your children?

I am interested in knowing more about your spiritual or religious way of living.

1. Could you tell me about the relationship between religion and health? Religion and care?
2. What religious rituals or ceremonies do you observe? How often do you observe them?
3. Are there certain beliefs concerning what or who influences mental illness?

V. Kinship and Gender

1. Can you tell me about male/female relationships, marriage and social unions in your culture?
2. Tell me about the elders in your community.

VI. Meaning and Experiences of Care

1. Can you tell me what care means to you? Can you give me examples?
2. Can you give me some words which describe a caring person?
3. Have you had experiences with people who are non-caring? If someone doesn't care, how would they express themselves?
4. Could you tell me about the Somali family and their caring ways? What are the strengths of the family?
5. In your culture, what ways do men show care? Women?

6. As you think about care, what do you think contributes to the development of a caring person and/or family or a caring institution, i.e. hospital, school or home?

VII. Professional and Folk Caring Factors

I would like to talk to you regarding your experiences with the health care system.

1. What has your experience with the health care system been like?
2. Tell me about a nurse who you think is caring.
3. Are there any differences in the care nurses have shown you?
4. What are your expectations regarding nursing care and/or medical treatment?
5. While in the hospital, what things would you like the nurse to do to show care?
6. Have you ever received care from a healer that is not a doctor in the hospital or a clinic? If yes, who and how did they show care?
7. Could you tell me about the traditional health remedies which you currently use? For what conditions or illnesses are they used?
8. What plants are utilized for prevention of illness and treatment of disease? How are they prepared and used?
9. What can you tell me about natural medicinal remedies used in your culture?
10. Is there anything else you would like for me to know regarding care and folk practices?
11. Can you tell me how mental illnesses can be prevented, diagnosed or treated in your culture?
12. When a family member is hospitalized, what roles do the family play during the course of treatment or hospitalization?

VIII. Technological Factors

1. Tell me about your ideas of technology and how it influences your way of life?
2. Are there any modern technologies or treatments that are preferred within your culture? If so, what are they? Are there any modern technologies or treatments that are avoided? If so, what are they?
3. Are there things that concern you about technology and health care?
4. Do you believe that technology interferes with human care? If so, in what ways?
5. What can you tell me about the use of technology in your culture?

IX. Political Factors

1. Tell me about the leaders in the Somali community?
2. Are there certain leaders who are known to be caring people? Who are they?
3. How do these leaders show care to the community as a whole? To individuals in the community?

X. Economic Factors

1. Are there barriers that you believe interfere with your ability to seek healthcare?
2. How do you pay for health services? For clinics?

XI. Environmental Context and DOI specific questions

1. What does mental health mean to you?
2. What does mental health mean in your culture?
3. Can you give me an example of mental health?
4. What does mental illness mean to you?
5. Can you give me an example of mental illness?
6. How is mental illness treated in the Somali culture?
7. Who provides the treatment?

8. Do you believe that the mental health facilities available are helpful?

9. Tell me what you know about nursing care?

10. What can a nurse do to promote mental health?

11. What can a nurse to treat mental illness?

12. Is there anything you would like me to know about your community and how it relates to your mental health?

Appendix F

Consent Forms

DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE:	Somali Immigrant Perceptions of Mental Health and Illness: An Ethnonursing Study
INVESTIGATOR:	Kimberly M. Gregg, PhD student 701 Park Ave. S., Minneapolis, MN 55415 (701) 741-1838 or (612) 873-2939
ADVISOR:	Rick Zoucha, PhD, APRN-BC Associate Professor, School of Nursing Duquesne University 526 Fisher Hall 600 Forbes Ave. Pittsburgh, PA 15221 (412) 396-6545
SOURCE OF SUPPORT:	None
PURPOSE:	You are being asked to participate in a research project that seeks to investigate Somali immigrants' perceptions of mental health and illness. You will be asked to allow me to interview you at least once and possibly up to three times. These are the only requests that will be made of you.
RISKS AND BENEFITS: life. In the affecting your mental a referral to a mental health	There are no risks greater than those encountered in everyday event that the interview appears to be negatively health, the interview will be stopped and provider made if appropriate.
COMPENSATION:	You will be offered a $10 gift card to Walgreen's to compensate you for your time. Participation in the project will require no monetary cost to you.
CONFIDENTIALITY:	Your name will never appear on any survey or research instrument used for this study. I will transcribe the tapes and no one else involved in the study will have access to your name. When the audiotapes are transcribed, all identifying information about you or anyone you talk about will be deleted. No identity will be made in the data analysis. Your response(s) may appear as de-identified

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quotes in summaries of findings and in reports of the data presented in publications and/or presentations. De-identified quotes may also be shared with members of my dissertation committee. All written materials, consent forms, and tapes used in this study will be stored in a locked file in my home and will be destroyed five years after all activities related to the study are completed.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Kimberly M. Gregg PhD student (701) 741-1838 or (612) 873-2930, Rick Zoucha, PhD, student advisor (412) 396-6545, and Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board 412-396-6326.

_____   _____

Participant's Signature   Date

_____   _____

Researcher's Signature   Date

Oggolaansho ka Qaybgal Cilmi Baaris

Cinwaan:	Soomaalida soo qaxday waxay ka qabaan caafimaadka maskaxda iyo cudurada ku dhaca.
Cilmi baare :	Kimberly M. Gregg, PhD student 701 Park Ave, S. Minneapolis, MN55415. (701) 741-1838 or (612) 873-2939.
La taliyaha:	Rick Zoucha, PhD, APRN-BC Associate Professor, School of Nursing Duquesne University 526 Fisher Hall 600 Forbes Ave. Pittsburgh, PA 15221 (412)396-6545
Ilaha Taageero:	International Society of Psychiatric- Mental Health Nurses Foundation Mental Health and Wellness Research Scholarship.
Ujeeddo:	Waxaa lagu warsanayaa inaad ka qayb gasho cilmi baaris wax looga ogaanayo Soomaalida soo qaxday waxay ka qabaan caafimaadka maskaxda iyo cudurrada ku dhaca. Waxaan ku warsan doonaa inaan ku waraysto ugu yaraan hal mar, ugu badnaanna saddex jeer. Intaa oo kaliya ayaa lagu warsan doonaa.
Dhib iyo dheef :	Ma jirto khatar kaweyn midda aad nolol maalmeed kaaga kala kulantid. Hadday u muuqato in waraysigu wax yeelayo Caafimaadka Maskaxdaada, waraysiga waa la joojin doonaa waxaana lagu la xiriirin doonaa qof daryeela caafimaadka maskaxda.
Magdhow :	Waxaa lagu siin doonaa Kaar qiimihiisu yahay $10 oo aad dukaanka Walgreens wax uga iibsan karto. Ka qeybgalka baaritaankana lacag kaagama baxayso.
Qarsoodi :	Marnaba magacaagu kama muuqan doono xaashiyaha ama qalabka baaritaanka loo isticmaalay. Cajaladaha wax lagu

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duubo qoraal baan u rogayaa, dad kale oo baaritaanka ka shaqeeya ma arkikaraan. Markaan cajaladaha qoro wixii laga fahmi **k**aro aqoonsigaaga ama kan qof aad ka hadashay waa la tirtirayaa.

Ma jiro wax aqoonsi ah oo ku jira xogta la falanqaynayo. Jawaabahaaguna waxay u muuqan karaan ayaga oo maldahan oo ka mid ah khulaasada natiijada baaritaanka iyo qoraallada la daabici doono ama fagaarayaasha laga soo jeedin doono. Waxyaalaha iyagoo maldahan la soo xigto waxaan la wadaagi karaa xubnaha guddiga qalin-jabintayda. Waxyaalaha qoran oo dhan, waraaqaha oggolaanshaha, cajaladaha loo isticmaalay daraasaddaan waxaa lagu kaydin doonaa fayl xiran oo gurigeyga yaal waxaana la burburin doonaa shan sano kadib marka ay dhammaadaan hawlaha la xiriira daraasaddaan.

| **Xaqqa Ka-Noqoshada:** | Ka qayb-galka cilmi-baaristaan sina uguma khasbanid. Waxaad xor u tahay in aad ka laabato oggolaanshahaagii ka Qayb-galka Markasta. |

| **Natiijooyin kooban:** | Natiijooyin Kooban oo Cilmi baaristaan ah ayaa lagu siin doona haddaad codsato, wax kharash ahna lagama rabo. |

| **Oggolaansho iskey ah:** | Waan akhriyey oraahda kor ku qoran waana fahmay waxa layga codsaday. Waxaan kaloo fahmay in ka qayb-galkaygu yahay mid aan iskey u doortay, markaan doonana ka laaban karo oggolaanshahayga, sababtu wax kasta ha ahaatee. Markaan eegay shuruudahaan, waxaan qirayaa inaan doonayo inaan ka qayb galo mashruucaan cilmi-baarista ah. |

Waxaan fahmay haddaan su'aalo ka qabo ka qayb-galkayga daraassaddaan, inaan wici karo Kimberly M. Gregg PhD student (701)741-1838 or (612) 873-2930, Rick Zoucha, PhD student advisor (412) 396-6545, and Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board 412-396-6326.

_____   _____

Saxiixa Ka Qayb-Galaha   Taariikh

_____   _____

Saxiixa Cilmi_Baaraha   Taariikh

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Appendix G

Gatekeeper/Interpreter Confidentiality Statement

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Confidentiality Statement

As a gatekeeper and/or interpreter you may be in the room during the study participant interviews. By signing this document, you agree to maintain this information in a confidential manner at all times. This includes but is not limited to:

• Disclosing confidential information to research data other than the principle investigator;
• Intentional or negligent mishandling of confidential information;

I acknowledge and agree to the above requirements.

Name: _____
(Please print)

Signature/Date: _____ / _____

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