E. Project Salaam: Assessing Mental Health Needs Among San Diego's Greater Middle Eastern and East African Communities

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Introduction

Greater Middle Eastern and East African communities in the United States face multiple challenges. First, many are immigrants and refugees who find themselves in unfamiliar environments. Acculturating to a new country (eg, learning a new language and different societal rules, changes in social status) is often stressful.[1] In Middle Eastern communities, as in other culturally and linguistically distinct groups, related problems can be handed down to second and third generations.[2]

Secondly, many Middle Eastern and East African immigrants have experienced adverse circumstances such as war, persecution, imprisonment and torture in their countries of origin. The 2004 World Refugee Survey, for example, lists Palestinians, Afghans, Iraqis and Iranians as constituting some of the largest refugee groups in the world.[3] Not surprisingly, people in such circumstances can encounter multiple, severe and sustained stressors.

Third, harassment and discrimination aimed at greater Middle Eastern communities increased after the 9/11 terrorist attacks.[4] Anti-Muslim and anti-Middle Eastern biases in the United States are nothing new.[5,6] But given the constant and ongoing public focus on US–Middle Eastern conflicts, it seems unlikely that a heightened negative focus on these groups will abate in the near future. Harassment has included overt hate crimes (eg, beatings, vandalism, murder) and more subtle forms of discrimination.[7,8] These reactions have not been limited to Arabs and Muslims, but have extended to anyone with features similar to those of a Middle Easterner (eg, Indian Sikhs).[9]

Calls to meet the mental health needs of Middle Eastern and East African origin communities in the United States have been made for two decades[10] yet these populations remain poorly understood. Little information exists on the psychological correlates of harassment and accumulated stressors in these groups. Project Salaam assessed such issues among San Diego, California's Greater Middle Eastern and East African groups. It identified relationships between psychological symptoms and history of trauma / adverse experiences, acculturation stresses, and sociodemographics. It further assessed personal coping skills, attitudes toward mental health services, and general healthcare preferences.

Methods

Data came from 360 written surveys, 10 structured focus groups (79 adults / 50 adolescents) and 20 key stakeholder interviews. All participants were of Greater Middle Eastern or East African origin or descent. They were recruited through local community- and faith-based organizations, schools, fliers, businesses serving the study's populations, and word-of-mouth. Activities were conducted in English, Arabic, Farsi, Somali or Russian as needed by a fully bilingual / bicultural Project Salaam staff.

The survey asked about demographics, experiences with adverse events, attitudes toward mental health services, personal coping efforts, healthcare preferences and encounters with healthcare systems in the United States. It also included the Traumatic Event Sequelae Inventory[11] and acculturation measures adapted from the literature.[12,13] Struc-

tured interviews also asked about participants' experiences with any adverse incidents. If such events were reported, respondents were asked to comment on why they believed the events happened, their emotional reactions, and if/how the events affected day-to-day life. Focus group and stakeholder transcripts were reviewed for primary themes. Descriptive statistics provided an overview of survey response patterns. Standard multiple regression then identified predictors of psychological distress. Qualitative and quantitative results were integrated by identifying consistencies across data types.

Table 1. Standard Multiple Regression: Predictors of Psychological Symptoms

Predictors	β	t	p
Adverse Event in Country of Origin	.27	3.56	<.0001
Adverse Event in the US	.31	4.11	<.0001
Adverse Event in both Home Country & US (Interaction)	.18	2.06	.04
Limited English Proficiency	.17	2.51	.01
Gender (Female)	.15	2.77	.006
Acculturation Stress	.25	4.56	<.0001
US Mainstream Orientation	−.12	−1.67	.09
Home Country Orientation	.08	1.27	.21
Age	.06	1.13	.26
Education	.06	1.00	.32
Monthly Income	−.09	−1.49	.14
Generational Status	−.04	−0.78	.43
Ethnic or National Origins / Descent*	.04	0.48	.63

(R^2 =.40; F=8.39, P<.0001); N=360
* Variable was dummy coded.

RESULTS

Participants in all study groups were largely immigrants (eg, 93% of the survey and 83% of the focus group). Most self-identified as Muslim; but those from Christian denominations (eg, Chaldeans) and the Bahá'í faith were also represented. Ethnic / national background among survey respondents included Somali (22%), Afghan (21%), Arab (17%), Kurdish (7%), Iranian (5%), and a variety of other nationalities (eg, Sudanese, Ethiopian, Lebanese, Turkish, Palestinian, Algerian, Moroccan, Egyptian and Jordanian). Similarly, focus groups and key stakeholder interviews included those from Lebanese, Iraqi, Egyptian, Syrian, Sudanese and other Greater Middle Eastern / East African backgrounds. While a majority of participants across activities described having limited economic means, a broader spectrum of education and income was also represented.

Thirty-seven percent of survey respondents described encountering harassment or discrimination in the United States. They attributed such events to reactions to the 9/11 terrorist attacks and to the continuing public focus on US-Middle East conflicts. Muslims, Arabs and those in traditional clothing appeared most at-risk. Circumstances ranged from subtle discrimination to violent confrontations. Harassment and discrimination in public, at the workplace, near home, at school (among adolescents), and by governmental entities was most frequently mentioned. In addition, 56% of immigrants recounted being persecuted in their home country. Seventeen percent of these described being tortured. Similar patterns were noted among focus group participants and key stakeholders. Almost all participants concurred that adverse experiences in country of origin and/or in the United States were common problems in their respective communities; yet 64% of those experiencing US-based incidents had not reported them to any authorities. Among those who made such reports, only 12% were satisfied with the outcome. Primary reasons for not reporting were: 1) not knowing procedures for doing so; 2) belief that it would be ineffective; and 3) not wanting to draw attention to themselves.

Adults most often described personal difficulties, including: problems expressing feelings (57%); trouble working (55%); helplessness (52%); impaired concentration (52%); nervousness (52%); and detachment (51%). Adverse experiences in the United States were most often connected with anger, loneliness and interpersonal (eg, family) problems. Persecution in country of origin was especially linked with thoughts of death and difficulties expressing feelings. Adolescents who had been harassed tended to describe increased nervousness, frustration, anger, and acting out (eg, fighting with other students at school).

Standard multiple regression analysis identified being female (P=.006), limited English proficiency (P =.01), acculturation stress (P<.0001), country-of-origin persecution (P<.0001), US-based harassment (P <.0001), and the interaction between adverse experiences in the United States and country of origin (P=.04) as predicting distress. The full regression model is presented in Table 1. Fifty-four percent of those reporting adverse United States and home-country experiences had symptom profiles similar to those diagnosed with post-traumatic stress disorder in the general population. This was also true for 49% of persons reporting home-country persecution only, 35% of those reporting adverse US experiences only, and 14% of those describing no adverse events.

Despite such difficulties, respondents described professional mental health services as unavailable to them. They discussed social stigmas and the lack of culturally, religiously knowledgeable providers as barriers. Other barriers included lack of health insurance,

language difficulties and poor treatment by providers and support staff. Among survey respondents, 16% had stopped going for care because of poor treatment by providers.

DISCUSSION

Results show mental health needs among the studied groups as substantial. Those who have experienced adverse events in the United States and in their country of origin are particularly affected. This result supports previous findings that vulnerability to new trauma is increased by past trauma.[14] At the same time, culturally effective care is often lacking. Adequate service development will require education of community members, providers and other stakeholders.

Project Salaam's long-term goal is to implement a systematic approach that includes: 1) professional training to increase cultural competence among healthcare providers, educators, social service workers, policy makers and other stakeholders; 2) education of broader society to reduce misconceptions and stereotypes about persons of Greater Middle Eastern and East African background; and 3) psycho-educational activities for community members that expand their ability to access health and social services and enhance their personal means to cope with stressors.

Given the project's partnership with a mosque, the sample is skewed toward Muslims with strong religious adherence. In addition, it is primarily made up of immigrants. Consequently, results may have limited generalizability to persons with no religious convictions, those born in the United States and those from Middle Eastern/East African backgrounds not in this sample. Despite these limitations, the identified number of people in need of mental health care is noteworthy. Overall, the study serves as one empirical effort to bring needed attention to the circumstances faced by Middle Eastern and East African communities in the United States.

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