UNIVERSITY OF CALIFORNIA SAN DIEGO

Association Between Acculturative Stress and Healthcare Seeking Among Iraqi Refugees

A Thesis submitted in partial satisfaction of the requirements
for the degree Master of Arts

in

Global Health

by

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2022

The Thesis of Khadiga Fouad is approved, and it is acceptable in quality and form for publication on microfilm and electronically.

University of California San Diego

2022

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ACKNOWLEDGEMENTS

I would like to acknowledge and thank my advisor and chair, Dr. Wael Al-Delaimy, who made this work possible. The completion of this study could not have been possible without his guidance and advice. I would also like to thank my committee members, Dr. Bonnie Kaiser, and Dr. Saiba Varma for serving on my committee and for their much-appreciated comments, suggestions, and continuous support. A special thank you to Dr. Seth Hannah whose guidance and advice has been invaluable. I must also thank the participants who contributed their experiences, without them this thesis would not have been possible.

I would like to express my deep appreciation for my family and friends for their love and support throughout my undergraduate and graduate studies. I would also like to thank my fiancé for his unwavering encouragement and understanding, you have truly made this year much easier.

Chapter 4, in part, is currently being prepared for submission for publication of the material. Fouad, Khadiga; Al-Delaimy, Wael K. The thesis author was the primary researcher and author of this material.

ABSTRACT OF THE THESIS

Association Between Acculturative Stress and Healthcare Seeking Among Iraqi Refugees

by

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Master of Arts in Global Health

University of California San Diego, 2022

Professor Wael Al-Delaimy, Chair

Introduction: The current refugee crisis is the most pressing global challenge, threatening the safety, wellbeing, and quality of life of 80 million forcibly displaced individuals. Refugees' experiences of pre-and post-migration trauma, post-migratory stressors, the additional burden of resettling in a new country, and a history of mental illness make the acculturation process of refugees unimaginably difficult and taxing, both mentally and physically. There is a lack of research exploring acculturative stress as a barrier to seeking healthcare.

Methods: Participants in this study consisted of 213 Iraqi refugee women resettled in San Diego, California. The Social, Attitudinal, Familial, and Environmental Acculturative Stress (SAFE) scale was used to assess acculturative stress in the sample. Healthcare access, history of mental illness, and demographic information were also collected. Statistical analyses included analysis of variance (ANOVA), Tukey post-hoc pairwise testing, Mann-Whitney two-sum rank tests, t-test procedures, and chi-square tests to determine the association between acculturative stress and healthcare access. A Directed Acyclic Graph (DAG) was constructed to represent the focal relationship and confounding variables.

Results: Quantitative analysis indicated higher levels of acculturative stress are associated with lower levels of education, increased financial strain, history of mental illness, and seeking mental health care. Predictors of acculturative stress specifically increased financial strain and history of mental health were also significantly associated with putting off or not seeking healthcare.

Conclusion: The results of this study highlight the barriers to healthcare services refugees face upon resettlement. An understanding of these barriers will help with targeted interventions to ensure the health and wellbeing of refugees. Future research should examine qualitative reasons why refugees postpone care.

CHAPTER 1 INTRODUCTION

Refugees are exposed to unimaginable living circumstances in their home countries that force them to flee to neighboring host nations, in hopes of finding a safe space, free of war and violence. Refugees and migrants exposed to great adversity experience an increased prevalence of anxiety, depression, and PTSD when compared to other immigrant populations.[1,2] They endure the pain of losing their loved ones, leaving behind family members, and losing their homes, jobs, and possessions. They face war and fear of persecution in their home countries, leading to social disorder and disruptions to their daily lives. During times of mass conflict, integral infrastructure such as educational institutions and healthcare delivery systems are destroyed, leaving refugees without access to basic services. While in transit, refugees face uncertainty and insecurity that further exacerbate their mental and physical health statuses. Upon resettlement, refugees face various stressors relating to language, employment, housing, healthcare access, cultural differences, and prejudice that leave them in a continuing state of vulnerability.[3]

The United States has worked to resettle over 3.1 million refugees since the establishment of the Refugee Act in 1980.[4] Texas and California are among the top states receiving refugees, with each state accepting more than 50,000 refugees between 2010 and 2021.[5] Upon arrival in the U.S, refugees are provided with health insurance called Refugee Medical Assistance (RMA) for those who do not qualify for Medicaid. RMA is available for up to eight months. Even though refugees are promised health insurance on arrival, there is often a delay in the activation of benefits, leading to a gap in medical coverage.[6] Other forms of assistance include a one-time payment of $900 when refugees first arrive and eight months of Refugee Cash Assistance (RCA). Those who qualify for Temporary Assistance to Needy Families (TANF) will not receive

RCA benefits but will begin receiving TANF funds for up to five years. The amount of money given is based on family size, for instance, a single person would receive $230 a month, and a family of two would receive $363 a month, etc., the amount of money increases as the family size increases. In addition to this, refugee elders (65+) will receive Supplemental Security Income (SSI) in the amount of $674 a month.[7]

The post-migration/resettlement process presents refugees with a unique set of challenges and stressors, such as difficulties with language proficiency, pressures to assimilate, separation from familial support systems, experiences of discrimination and prejudice, and intergenerational family conflicts.[8] Acculturative stress is a very specific type of stress that migrants (immigrants, refugees, asylum seekers, etc.) experience upon resettlement in a new country. The concept of acculturative stress is used to understand the negative behavioral and emotional reactions that are a result of the process and experience of adapting to and engaging with a new social and cultural environment.[9] The tension and psychological burden of acculturation threaten the mental health of immigrants and their future generations.[10]

The purpose of the current study is to understand the impact of acculturative stress on healthcare utilization among refugee populations. Additionally, the study sets out to identify what factors influence health-seeking behaviors in recently resettled Iraqi refugee women, what is the relationship between acculturative stress and health-seeking behaviors, and what other variables influence acculturative stress levels. The following sections of this proposal will review the literature on the following topics pertinent to this study on acculturative stress and refugee health: a) stages of the refugee migration process, b) acculturative stress in immigrant and refugee populations, c) predictors of acculturative stress, c) the impact of acculturative stress on

mental health outcomes, d) barriers to healthcare access and utilization e) the impact of acculturative stress on health-seeking behaviors.

There is little empirical evidence that shows if and how there is an association between acculturation/acculturative stress and health care utilization. The current study aims to highlight refugees' need for continuous formal and informal (i.e, institutional and community) support upon resettlement and to address the multitude of barriers refugees face when accessing healthcare services. Many of the factors that limit refugees' ability to access and utilize health care services are interrelated and must be addressed in a holistic manner. Refugee health must be viewed through an intersectional lens to fully grasp the processes, practices, policies, and structures that increase the vulnerability of refugees during resettlement.[11]

CHAPTER 2 LITERATURE REVIEW

2.1 Current State of Refugees

The current migration crisis is the most pressing global challenge, with the number of forcibly displaced individuals at a record high and counting. It is important to distinguish between voluntary migrants and forced migrants (refugees and asylum seekers). The International Organization for Migrants defined a migrant "a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons." The 1967 Protocol of the 1951 Refugee Convention defines a refugee "as a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him— or herself of the protection of that country, or to return there, for fear of persecution."[12]

According to the United Nations High Commissioner for Refugees, there were approximately 82.4 million forcibly displaced people at the end of 2020.[13] Refugees are forced to flee their home countries for several reasons, including, but not limited to, persecution, violence, conflict, and various other human rights violations. In addition to threats to their lives, refugees face potential threats to basic human rights, such as food, shelter, and water. They may also lose access to education and work, resulting in a loss of income and stability. Upon resettlement, refugees face countless social, political, environmental, and economic stressors that impact their mental and physical health outcomes throughout the migration process.

2.2 Iraqi Refugee Crisis

As of 2020, there are 9.2 million Iraqis either internally displaced or seeking asylum in other countries, following the start of the Iraq war in 2003.[14,15] Iraqi refugees resettling in the United States mainly live in California, Michigan, and Texas.[16] The Center for Disease Control (CDC) reports approximately 20,240 Iraqi refugees resettled in California, mainly in San Diego.[16] Iraqi refugees in California find themselves mainly resettling in San Diego. More specifically, approximately 50,000 Iraqi refugees live in El Cajon, California. Iraqi refugees ethnically identify as Chaldean. Chaldeans are the largest non-Muslim Iraqi group and form the largest Christian group in the Middle East.[17]

Individuals living within Iraq find themselves subject to weakening basic political, social, and economic infrastructure and the dwindling of essential resources and economic opportunities. This deterioration leads to an increase in competition and tension between individuals living in Iraq.[18] Once individuals choose to begin their journey to safety, they are subject to a cycle of never-ending structural violence, thus facing a continuous threat to their health, wellbeing, and livelihood.

2.3 Stages of Migration

Pre-Migration

During the pre-migration phase, exposure to trauma and violence associated with experiences of war, political conflict, economic stress, and persecution heavily affect refugees' health. Persecution can be based on a variety of social factors, such as religion, race, ethnicity, gender, sexual orientation, or other social group membership. Compared to other migrants who have not been forcibly displaced, refugees typically have higher rates of suicidal ideation, post-traumatic stress disorder (PTSD), anxiety, and depressive symptoms.[8,19–21] The development of

PTSD, depression, and anxiety symptoms is highly correlated to the number of traumatic events or torture refugees may experience.[22,23] Such symptoms can persist and remain high for many years following a period of mass conflict and displacement.[24,25]

Migration/In Transit

Refugees face much uncertainty throughout the migration process regarding their present and future states. En route to the transit or host country, access to necessities, such as food, water, and shelter, is threatened. Refugees are offered three options: 1) voluntary return to their home country without compromising the safety of the individuals, 2) integration into the asylum country's community, or 3) resettlement to another host country.[26] Depending on the refugee resettlement policies and laws of the country of asylum, refugees may live in refugee camps or integrate temporarily into the host community before resettlement in another country.

Living in a refugee camp poses its own set of health risks and challenges. The conditions of refugee camps undermine the health, wellbeing, and safety of refugees and asylum seekers. Individuals face limited access to water, sanitation, hygiene facilities, and essential healthcare services and live within close proximity to others.[27] These poor living conditions can lead to the increased spread of viruses and bacteria throughout refugee camps. Refugees and asylum seekers often overlook or postpone seeking healthcare while in transit to prioritize finding shelter, food, water, and other essentials.[1]

According to the World Health Organization (WHO), the most common health issues newly arrived refugees and migrants face include hypothermia, gastrointestinal illnesses, cardiovascular conditions, pregnancy- and delivery-related complications, diabetes, and hypertension.[1] While refugees and asylum seekers are directly impacted by the spread of communicable and infectious diseases while in transit, individuals who suffer from chronic

noncommunicable diseases (NCDs) are also at risk of exacerbating their conditions due to the dangerous living conditions they face. Additionally, the uncertainty of the migration journey leads to the interruption of treatments and care necessary to manage NCDs. If left untreated, NCDs can be life-threatening. It is important to note that unsuccessful detection and treatment of NCDs may hinder refugees' ability to seek out and hold onto long-term employment opportunities once resettled, thus increasing economic struggles.[28]

At every stage of the migration process, refugees face constant ill-treatment and abuse. Thus, adding to the burden of torture they experienced in their home countries before fleeing. This further impacts their short and long-term physical and mental health and wellbeing. For instance, women and girls are at an increased risk for sexual and gender-based violence. They face an added layer of vulnerability due to an increased risk of intimate partner violence, sexual violence, exploitation, trafficking, child marriage, and female genital mutilation.[29] Furthermore, refugees face threats of violence from security forces while attempting to cross into host countries, humanitarian aid workers within refugee camps, and members of the host country who may view refugees as competition over access to resources, services, and facilities.[30,31]

Post-Migration/Resettlement

During the post-migration phase, refugees face stressors related to the resettlement process, including language barriers, social and familial isolation, xenophobia, Islamophobia, discrimination, and racism; lack of access to job and educational opportunities, safe and clean housing, and transportation; and limited income support.[8,32–35] This loss of social support networks and likely decline in socioeconomic status can significantly hinder their integration into host communities, leading to isolation of refugee populations.[36] Psychological distress is exacerbated due to the constant instability linked with unemployment, language barriers, and

legal issues accompanying the resettlement process. Refugees' job opportunities may be negatively influenced by the lack of recognition of work skills and educational achievements previously attained in their home countries.[22] Cultural norms also play a role in how refugees define, understand, and treat their physical and mental health.[37,38] Religious beliefs, practices, and visible religious symbols may also challenge seamlessly assimilating and integrating into the host country's society.

2.4 Acculturation and Acculturative Stress

Acculturation is commonly defined as how migrants grow acclimated to a new country and culture and develop a relationship with the new culture while maintaining ties to their own culture.[39] Therefore, migrants undergo various changes when being introduced to the norms and traditions of a different culture and forge a space for themselves in their new communities.[40] This process was originally seen as a group-level, unidimensional, and eventually irreversible phenomenon. Within which, migrants acquire the new cultures' values, practices, and beliefs, subsequently disregarding their original cultural traditions.[39,40] However, acculturation has proven to be a multifaceted process influenced by numerous contextual factors under which both the migrants' own culture and the new host country's culture influence one another.[40–42] The four possible outcomes of the acculturation process include: assimilating into the dominant host country's culture, integrating, or combining one's own culture into the host country's culture, rejecting the host country's culture, or completely separating one's own culture from the host country's dominant culture.[8,19,40,43]

Sam and Berry propose that the dominant host community plays a role in either encouraging or hindering the acculturation process of refugees. For instance, if the dominant culture encouragingly supports the target population in taking on new behaviors, such as learning

a new language or acquiring new, widely accepted behaviors, the acculturation process will be more successful.[44] William and Berry also emphasize the importance of the individual's role in and perception of the acculturative process. Individuals who recognize changes arising from acculturation as opportunities for growth rather than overwhelming barriers may experience better mental health outcomes and less acculturative stress.[45]

Acculturation can be broken down into a cultural or group phenomenon and an individual phenomenon referred to as "psychological acculturation."[39,46] Acculturation suggests that those part of a cultural minority collectively facing acculturation undergo physical, biological, behavioral, cultural, and social changes.[39] First, physical changes can be due to shifts in living spaces; this may encompass the type of community, the type of housing, the population density, or even the air quality. Second, biological changes can introduce new foods or encounter new diseases. Third, behavioral changes due to the acquisition of a new language, practices, beliefs, and customs may lead to changes in mental health status. Fourth, cultural changes can be related to the shift in political, economic, technical, linguistic, religious, and social foundations. Lastly, social changes refer to changes in social relationships and family structures.[39,42,47]

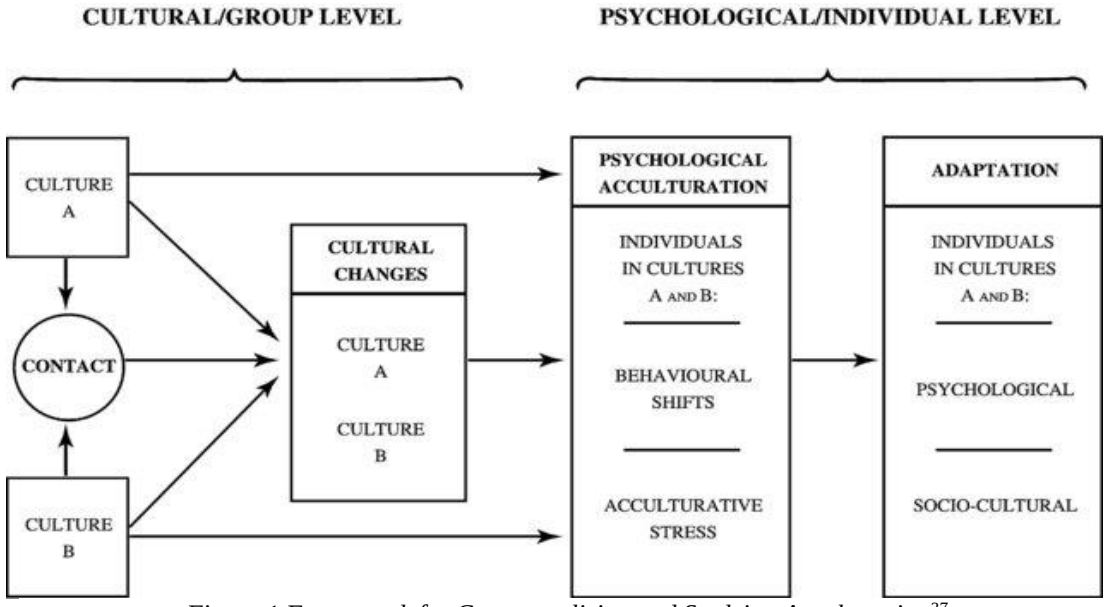

Figure 1 Framework for Conceptualizing and Studying Acculturation[37]

It is important to note that cultural changes may be due to the cultural exchange of beliefs and ideas between the dominant majority and incoming minority cultures. Additionally, those of the dominant culture may feel pressured to alter their social and political infrastructure to accommodate the influx of newcomers. Likewise, migrants feel the need to assess whether it is more beneficial to hold onto their cultural identity or if there is a greater benefit to take on a new cultural identity to cultivate and maintain a relationship with the host country's governing society.[47]

Acculturative stress is the stress one feels that can be coupled with feelings of low self-esteem, anxiety, depression, and other difficulties resulting from adjustment to a new culture and environment, experiences of ostracism and alienation, and other related acculturation stressors.[8,39,43,48] Increased levels of depression and anxiety may be associated with feelings of cultural loss and uncertainty.[44] Therefore, acculturative stress is believed to be a direct byproduct of the acculturation process, leading to poorer mental health outcomes and psychological distress.[39,48]

Predictors of Acculturative Stress

The effect of acculturation is tied to many factors at the individual, interpersonal, community, and policy levels that mediate the relationship between acculturation and acculturative stress. At the individual level, education, language proficiency, employment, socioeconomic status, religious identification, and personal factors, such as self-esteem, may either lessen or exacerbate levels of acculturative stress. When assessing an individual's ability or inability to acculturate into the dominant culture, available social and familial support must also be considered to understand higher levels of acculturative stress.[48–50]

Research has shown that higher levels of education are a consistent predictor of low levels of (general) stress and depression.[39,51,52] There are a few theories around why education is correlated with low levels of acculturative stress. First, the ability to access educational opportunities in the host country allows migrants gradual exposure to the dominant cultural and societal practices and norms. Second, a higher level of education is associated with the increased ability to access intellectual, economic, and social resources, thus allowing for healthier coping mechanisms upon resettlement.[39,51]

Studies found that lower socioeconomic status, unstable working conditions, and unemployment are essential mediators of mental health among immigrants. A comparison between ethnic Norwegians and ethnic Pakistanis living in Oslo, Norway, indicated that Pakistanis experienced higher rates of distress in relation to lower levels of education and lower employment rates. [53] Another study demonstrated the relationship between employment rates and levels of acculturative stress. Amerasians, individuals born to American servicemen and Vietnamese or Cambodian women during the Vietnam War, who lived in the United States and were employed, experienced less acculturative stress than those who were unemployed.[54]

At the community level, discrimination is a significant acculturation stressor. Increased experiences of personal and systemic racial, ethnic, and religious discrimination negatively impact migrants' physical and mental health and wellbeing. Moreover, migrants affected by higher numbers of discriminatory events experience higher levels of acculturative stress.[51] Discrimination can decrease how migrants partake in social and community activities, which are considered protective factors for mental health. Furthermore, discrimination hinders access to healthcare services and facilities. Lastly, institutional factors, such as the reason for immigration,

migration status, length of stay in the host country, and immigration policies in place, significantly impact levels of acculturative stress.[49]

When approaching acculturation and understanding the development of acculturative stress, it is vital to utilize an intersectional approach. Each of the mentioned factors, among others, impact how refugees and asylum seekers transition and cope with leaving behind their homes, processing the trauma experienced throughout the migration journey, and resettling in new host countries.

Acculturative Stress and Mental Health Outcomes

Refugee populations face unimaginable, traumatic conditions which increase their vulnerability to PTSD, depression, and anxiety. A study among Bosnian refugees in Austria and Australia found that acculturative stress is significantly associated with a decline in mental health post-migration. Austrian Bosnians with high levels of acculturative stress also experienced greater feelings of cultural loss and difficulties in language proficiency, thus increasing the severity and occurrence of their PTSD and anxiety symptoms, respectively.[55]

A study examining the pre-migratory, migratory, and post-migratory factors associated with mental disorders in war refugees found that sociodemographic factors, war-related experiences, and post-migratory stressors were individually related to the prevalence of mental disorders. Bogic et al. established that mood and anxiety disorders were independently associated with a lower level of education, a higher number of traumatic pre-and post-war experiences, feelings of rejection by the host society, and temporary residence status.[56] Hence, controlling for pre-migration trauma, refugee populations facing post-resettlement acculturative stressors consistently present with poorer mental health outcomes.[56,57] This supports the notion that

acculturative stressors relating to resettlement accumulate over time to negatively affect refugees' health, wellbeing, and quality of life.

People with mental illness face increased stigmatization and discrimination due to their disabilities. This stigma and discrimination are viewed as barriers to accessing mental health treatment and lead to an exacerbation of symptoms.[58] The stigma associated with mental illness can be divided into self-stigma and public stigma. Self-stigma refers to the negative beliefs and attitudes, and prejudice individuals with mental illness hold about themselves and their illness. [59,60] This form of stigma can decrease self-esteem, self-efficacy, and fear of rejection. The prejudice that people with mental illnesses face may lead them to experience a reduction in confidence, react to the injustice due to social stigma, or become indifferent, depending on the different factors individuals face. [60]

Public stigma refers to the general public's negative or discriminatory beliefs and attitudes towards people with mental illness. [59] Stigmatizing beliefs and attitudes lead to fear and exclusion of people with mental illnesses, the conviction that individuals are incapable of making life decisions and need to be cared for. Popular stereotypes about individuals with mental illness include that they are dangerous, incompetent, unpredictable, and to blame for their disorder. These stereotypes directly impact people with mental illness. For instance, employers, landlords, and healthcare providers who hold these beliefs may not hire them or may not rent to them or offer an inadequate standard of care. [59]

2.5 Barriers to Healthcare

Refugees experience structural, financial, and socio-cultural barriers to seeking and accessing healthcare, leading to delayed care and declining short and long-term health outcomes. [61,62] A combination of the lack of medical interpreters, inadequate language concordance

between refugee patient populations and their healthcare providers, unfamiliarity with the host country's health system, the financial burden of seeking care, and limited health literacy, among other factors, can affect early use of health care and use of preventive health care services. The inability to pay for health care services is only one aspect of the financial burden patients face. Inability to take time off work, daycare costs, cost and availability of transportation must also be considered when assessing refugees' utilization of health care services. [62,63]

Delayed care due to language barriers leads to increased follow-up costs, emergency room utilization, and hospitalization rates. [62,64,65] Additionally, those who experience language barriers while seeking care experience worse health outcomes and are less satisfied with the quality of care. [64,66] This dissatisfaction may be due to miscommunication between patients and healthcare providers, threatening patient safety. Language barriers also impede patients' understanding of their medical diagnoses and affect their adherence to treatment regimens and protocols. [66]

Women of refugee backgrounds, a particularly vulnerable population, face severe health risks that arise from experiencing continuous stressors before and after resettlement. Refugee women experience hardships in accessing stable accommodation, financial strain, and difficulty finding employment, leading to chronic instability. A study conducted among refugee women resettled in Australia identified several barriers to accessing mainstream mental health services, including lack of funding for services, causing services to be under-resourced, lack of culturally competent care, and lack of interpreters. Thus, further exacerbating and increasing the amount of stress women of refugee backgrounds endure. [67]

Acculturation and Accessing Healthcare

Markova et al. explored preferences in help-seeking behaviors for depression based on ethnic groups and the relationship to acculturation. Results showed that preferences differed based on ethnic affiliation, gender, level of education, and level of acculturation. Those who maintained ties to their culture of origin preferred traditional and informal help-seeking resources. In contrast, those who adopted the host country's dominant culture turned to semiformal and formal help-seeking resources. [68] A study conducted in the Netherlands among first-generation Turkish and Moroccan migrants looked at health services, specifically the utilization of general practitioners, outpatient specialists, and mental health specialists using self-report measures. Results from the Turkish migrant group showed positive associations between acculturation and healthcare service utilization. However, among the Moroccan migrant group, increased acculturation was associated with less outpatient care utilization. This reversal in associations may be due to varying degrees of social support among the two groups, varying levels/abilities to communicate in the host country's native language, and varying degrees of knowledge regarding how the host country's healthcare system works.[69]

CHAPTER 3 METHODS

3.1 Participants

The data used in the current study come from a larger project that included 213 Iraqi refugee women and 213 of their children, aged 6–13 years old. In the broader project, both the mothers and their children completed several questionnaires; only the mothers' data were used for analyses for the current study. Ethics approval was obtained from the Institutional Review Board at the University of California, San Diego before recruitment began. Iraqi refugees were recruited through organizations such as Catholic Charities and the International Rescue Committee partner with the San Diego Department of Public Health to provide resettled refugees with health screenings and follow-ups early in the resettlement process.

Eligibility criteria included Iraqi refugee women who arrived in San Diego County within five years from the beginning of the study in 2012 and had children between 6–13 years old. Catholic Charities provided a list of all recently resettled Iraqi refugee women in the past five years and 500 refugees were randomly selected and were contacted to participate. Of the 500, 250 participants agreed to enroll in the study and filled out an informed consent form. Overall, 31 participants withdrew from the study, and six were excluded for incomplete survey information, leaving 213 Iraqi refugee women. The questionnaires were read aloud to participants in Arabic, and enumerators recorded verbal responses. Participants were given a $20 incentive upon completion of the study.

3.2 Materials

Questionnaires assessed symptoms of depression and anxiety, acculturative stress, history of trauma and torture, perceived social status, healthcare access, and demographic information. For this study, only data collected regarding levels of acculturative stress, perceived social status,

healthcare access, and demographic information was utilized. To ensure cultural and linguistic appropriateness, all scales that were not already available in Arabic were translated to Arabic and then back-translated into English by independent members of the research team. The order of the questionnaires was the same for each participant.

Acculturative Stress

To assess levels of acculturative stress among participants, the Social, Attitudinal, Familial, and Environmental Acculturative Stress scale (SAFE) was used. It is a 24-item scale that has been found to be reliable for use among Arab immigrant populations.[8,70] The 24-item questionnaire measures perceived stress due to the internal and external factors associated with the acculturation process. Responses used a Likert scale from 1, "Not stressful," to 5, "Extremely stressful," with 0 as "Does not apply." Likert scale responses were used to create an index ranging from a sum of 0 to 120. The Cronbach alpha for the SAFE scale in this study was found to be 0.90.

Social Status and Financial Strain

Participants were asked to indicate their social status while living in Iraq and upon arriving and resettling in the United States using a ladder diagram of ten rungs. The top rung represents the highest social status, while the bottom rung represents the lowest status within the community. Participants were also asked to indicate how well the amount of money their family makes takes care of their needs to determine the amount of financial strain they are experiencing.

Healthcare Access and Mental Health

To assess health-seeking behaviors and attitudes, participants were asked a series of questions about where they seek help when sick or in need of healthcare, if they have put off

seeking care and the reasons why, and their experiences with the U.S healthcare system. Participants were also asked about their mental health histories.

Demographic Information

Age, religious affiliation, ethnic affiliation, marital status, education level, and participants' perception of life in the U.S after resettlement and their life in Iraq before migration were collected.

3.3 Analyses

Descriptive statistics were calculated for all key demographic characteristics and measures describing acculturative stress. Data analysis was performed using SAS version 9.4 through t-test procedures, analysis of variance (ANOVA), Mann-Whitney two-sample rank-sum tests, t-test procedures, and chi-square tests at a significance level of 0.05.

A Directed Acyclic Graph (DAG) was constructed using DAGitty, a web-based tool to create, edit, and analyze causal diagrams. A DAG is a tool utilized to design and develop the conceptual framework and analytical plan of a study. It displays the causal paths between exposure and outcome variables, categorizing the focal relationship while identifying confounders and sources of bias. Constructing the DAG begins with articulating the research question and determining the exposure (cause) and outcome (effect). Next, moderating variables (which affect the direction and/or strength between exposure and outcome) and mediating variables (which are affected by the exposure, which affects the outcome) are identified. Next, observed confounding variables are identified; these are factors that are common causes of both the exposure and outcome. And finally, other relevant, unmeasured variables are considered.[71] For this study, the DAG included the focal relationship of interest and observed confounding variables.

CHAPTER 4 RESULTS

4.1 Descriptive Results

The average age of the participants was 38.73 years old (range: 23–58). When the participants left Iraq, the average age was 33.05 years old (range: 13–53). Most of the participants were married (93.90%), spoke Chaldean at home (63.68%), were Catholic (80.75%), and had an education level of high school or below (73.23%). The participants' average summary score of acculturative stress was 37.44, with a standard deviation of 20.65 (range: 6-103; out of the possible range: 0-120) (see Table 1). Of the 213 participants, 78 (36.61%) participants reported a decrease in their social status upon arriving in the United States from Iraq. When asked about how well their family's financial needs were met, 108 (50.70%) felt their financial needs were well met, and 105 (49.30%) said they felt their financial needs were poorly met (see Table 1).

4.2 Correlation Between Acculturative Stress and Financial Strain

Due to the non-normal distribution of the data, a two-tailed Mann-Whitney two-sample rank-sum test was selected and used to examine whether there were significant differences in levels of acculturative stress between how well participants felt their needs were being met financially. Results showed that increased feelings of financial strain are significantly associated with higher levels of acculturative stress ($U = 12548.50$, $z = 2.92$, $p = 0.0035$). The median levels of acculturative stress for those who indicated that their financial needs were well met is 28.0 and for those who indicated that their financial needs were not well met is 37.0. Figure 2 presents a boxplot of the Ranks of Acculturative Stress by Financial Strain.

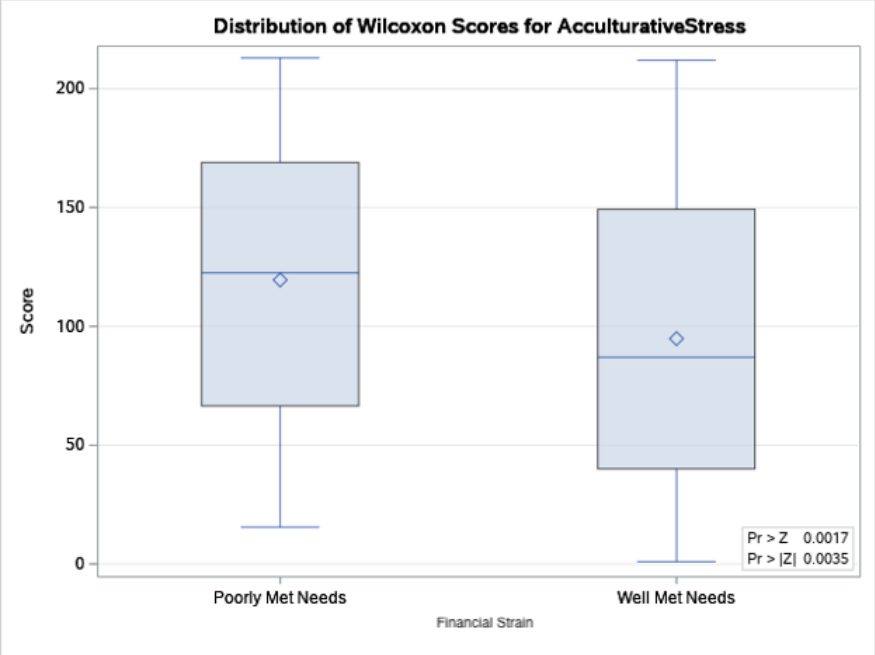

Figure 2 Ranks of Acculturative Stress by Financial Strain

4.3 Correlation Between Acculturative Stress and Level of Education

A one-way ANOVA test showed that participants' level of education had a statistically significant association with levels of acculturative stress ($F(6,206) = 2.42$, $p = 0.0276$). Tukey's post-hoc analysis showed that those who completed elementary school experienced significantly higher levels of acculturative stress than those who completed higher levels of education. More specifically, individuals who completed elementary school had higher acculturative stress levels ($N = 34$, $M = 46.82$, $SD = 23.64$) in comparison to those who completed up to middle school ($N = 51$, $M = 32.92$, $SD = 14.88$, $p = 0.0352$) or high school ($N = 69$, $M = 34.03$, $SD = 20.77$, $p = 0.0450$). There were no other significant differences found between the other levels of education ($p > 0.05$, see Figure 4). Figure 3 represents the Distribution of Average Acculturative Stress Scores Across Levels of Education.

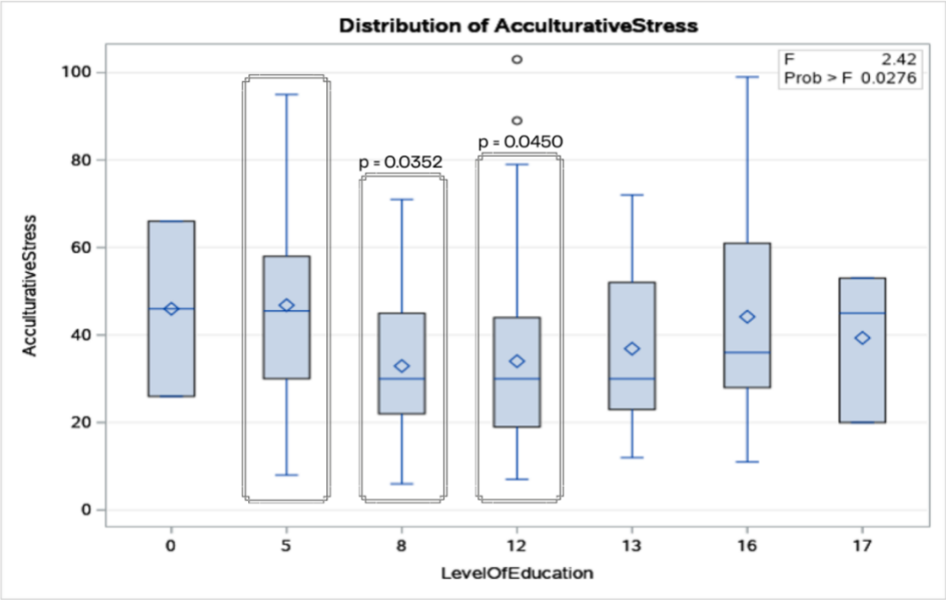

Figure 3 The Distribution of Average Acculturative Stress Scores Across Levels of Education (years)

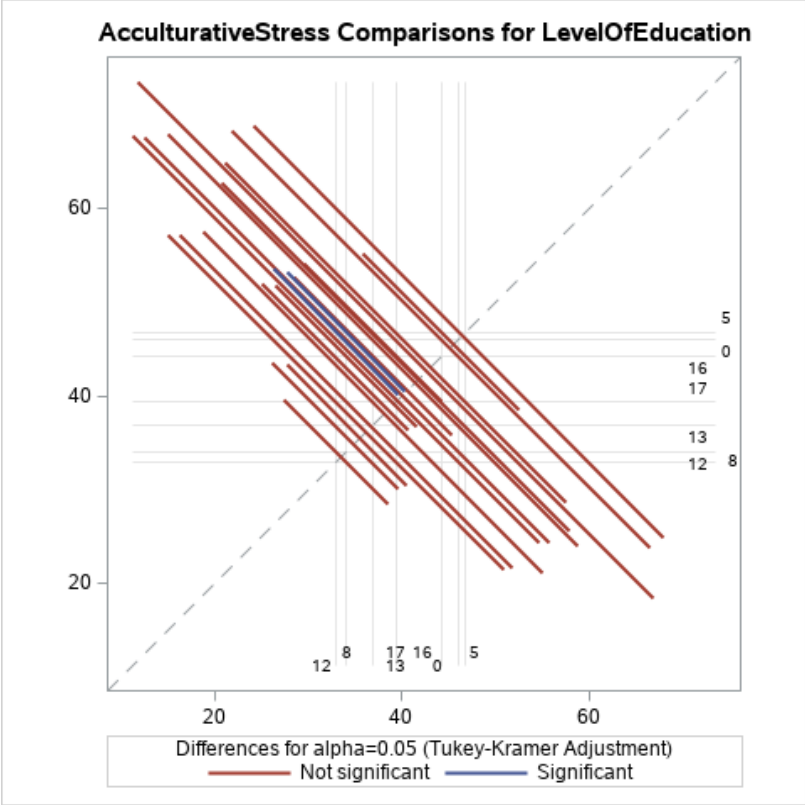

Figure 4 Significant Differences in Acculturative Stress Between the Levels of Education

4.4 Correlation Between Acculturative Stress and Accessing Mental Healthcare

Participants were asked, “Since you came to the US, were you able to see a doctor for a mental health problem if you had needed to?” to better understand whether Iraqi refugee women in this study were able to access mental health services in the United States. A total of 38 (17.64%) responded with yes, 45 (21.13%) responded with no, and 130 (61.03%) claimed that they did not need to see a mental health specialist. Figure 5 represents the Distribution of Acculturative Stress Across Accessing Mental Healthcare.

The one-way ANOVA test run to determine the relationship between the ability to access mental health services and levels of acculturative stress showed a significant relationship between accessing mental health services and high levels of acculturative stress ($F(2,210) = 5.93$, $p = 0.0031$). Those who were able to seek out mental health services experienced higher levels of acculturative stress ($N = 38$, $M = 47.66$, $SD = 23.10$) in comparison to those who were not able to ($N = 44$, $M = 35.04$, $SD = 16.55$, $p = 0.0139$) or who claimed that they did not need to seek out mental health care ($N = 130$, $M = 35.28$, $SD = 20.42$, $p = 0.0030$). No other significant differences were found between the other conditions ($p > 0.05$, see Figure 6).

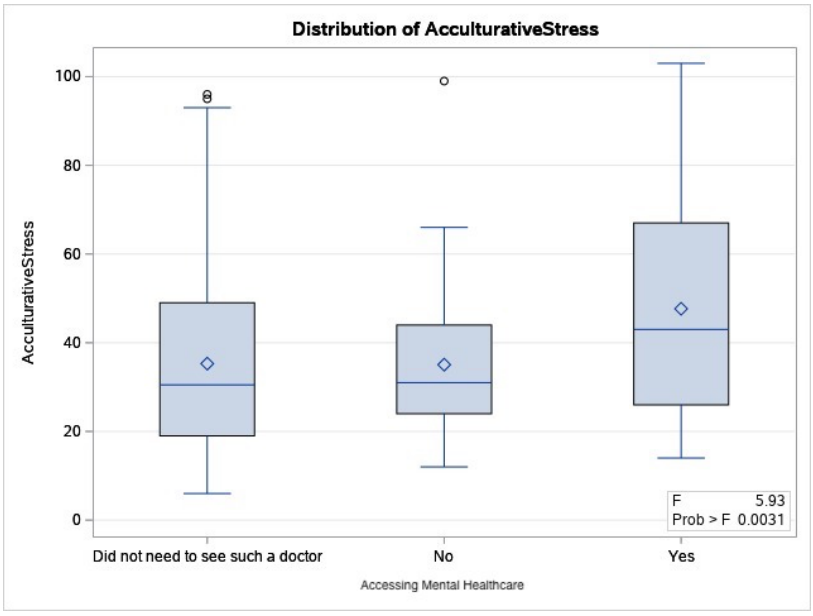

Figure 5 Distribution of Acculturative Stress Across Accessing Mental Healthcare

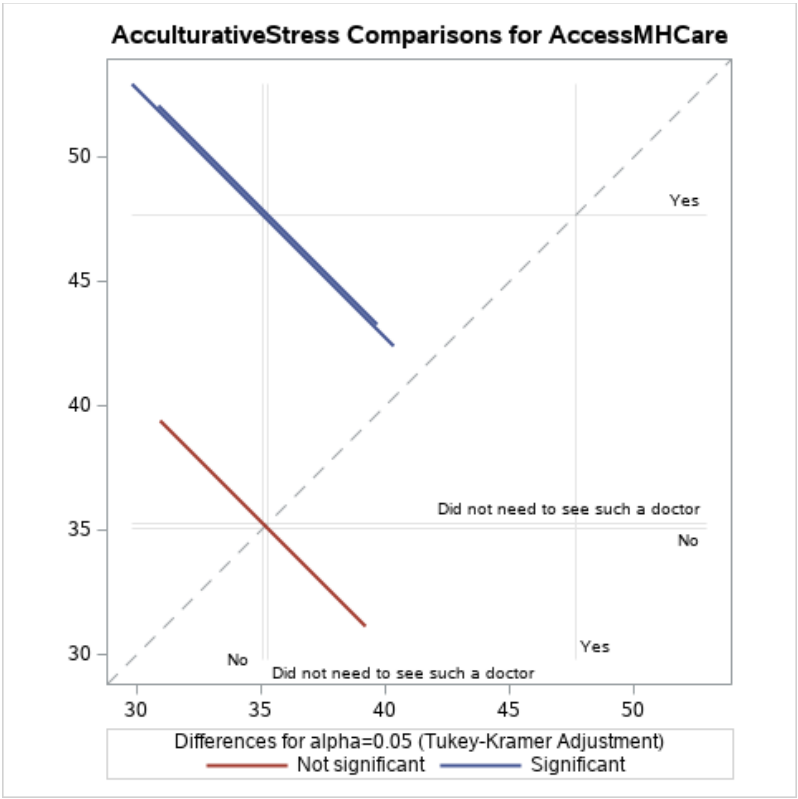

Figure 6 Significant Differences of Acculturative Stress Between Accessing Mental Healthcare

4.5 Correlation Between Acculturative Stress and History of Mental Illness

Information regarding the study participants' history of mental illness was also gathered. 45 (21.13%) of the participants reported a previous diagnosis of a psychiatric condition, while 168 (78.87%) participants were not previously diagnosed. A two-tailed Mann-Whitney two-sample rank-sum test was conducted to examine whether there were significant differences in levels of acculturative stress between those with and without previous psychiatric diagnoses. Results showed that a history of mental illness is significantly associated with increased acculturative stress levels ($U = 5836.00$, $z = 2.78$, $p = 0.0054$). The median level of acculturative stress for those who indicated a history of mental illness is 39.00, and those who indicated that they do not have a history of psychiatric conditions is 30.50. Figure 7 presents a boxplot of the ranks of Acculturative Stress by History of Psychiatric Diagnosis.

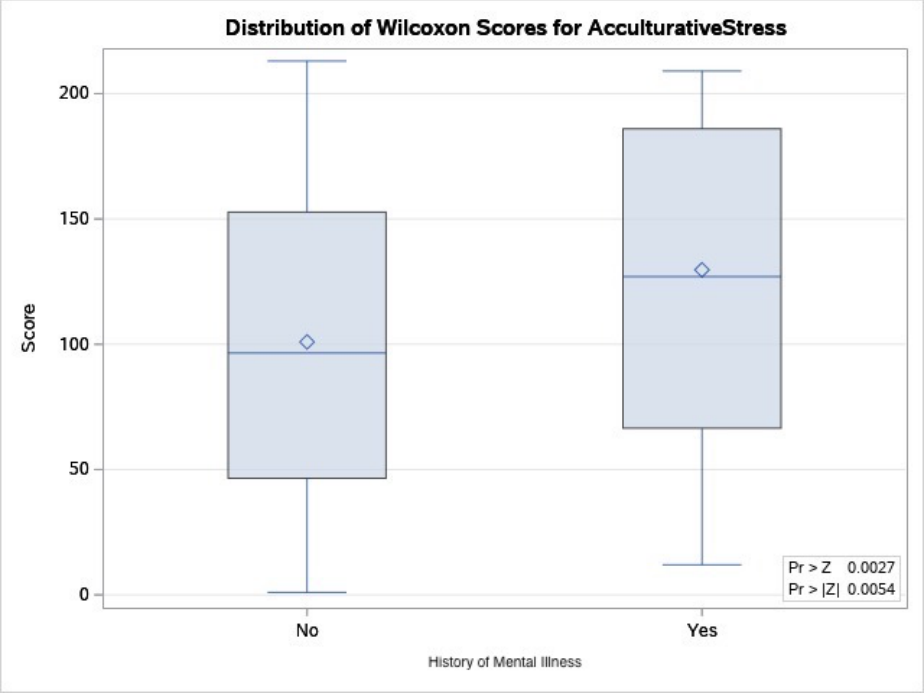

Figure 7 Ranks of Acculturative Stress by History of Mental Illness

4.6 Associations of History of Mental Illness and Financial Strain with Postponing Care

Participants were asked if they had put off, postponed, or did not seek medical care in the past 12 months. 64 (30.05%) participants indicated that yes, they did postpone care, while 149 (69.95%) participants did not postpone care. A chi-square test showed that those without a history of mental illness are more likely to seek out healthcare than those with a history of mental illness X^2 (1, N = 213) = 7.50, p = .0062. Additionally, those who reported that their financial needs were poorly met were more likely to report that they postponed or did not seek care X^2 (1, N = 213) = 11.72, p = .0006.

4.7 Associations of Level of Education with Healthcare Satisfaction and Treatment Preference

A chi-square test showed that participants with a lower level of education were more likely to be satisfied with the U.S healthcare system X^2 (1, N = 212) = 8.09, p = .0045. Additionally, participants were asked if they preferred to be treated by a doctor of their own race or ethnic group, another race or ethnic group, or no preference. A chi-square test showed that those with a lower level of education had no preference regarding the doctor's race or ethnicity, X^2 (2, N = 211) = 16.63, p = .0002.

4.8 Schematic Model of Factors Influencing Healthcare Access

Figure 8 is a visual representation of the relationship between acculturative stress, the exposure variable, and healthcare access, the outcome variable. History of mental illness, financial strain, and level of education act as confounding variables, influencing both acculturative stress and healthcare access, the independent and dependent variables, respectively.

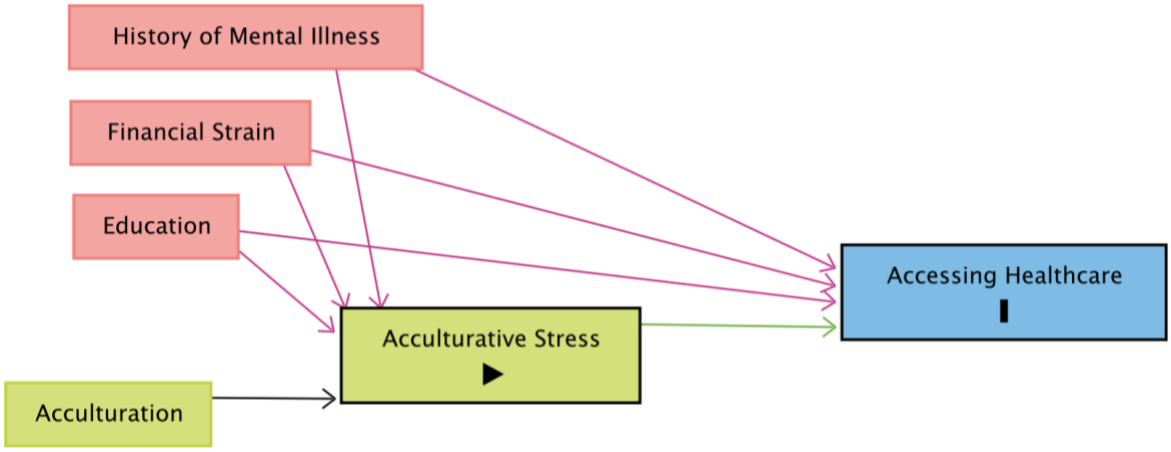

Figure 8 Schematic Model of Factors Influencing Healthcare Access

Chapter 4, in part, is currently being prepared for submission for publication of the material. Fouad, Khadiga; Al-Delaimy, Wael K. The thesis author was the primary researcher and author of this material.

CHAPTER 5 DISCUSSION

This study aimed to examine the factors affecting health-seeking behaviors among recently resettled Iraqi refugee women to understand barriers to healthcare among refugees further. Specifically, to understand how acculturative stress influences health-seeking behaviors. It was hypothesized that increased levels of acculturative stress lead to decreased healthcare utilization. This study also set out to identify what factors lead to increased levels of acculturative stress. Refugees arriving to host countries are experiencing high levels of anxiety, depression, and PTSD, greater than any other immigrant population.[1] On arrival, they are met with minimal resources and support from the host country's government and the general population. It is essential to understand barriers to healthcare among refugees as a step towards achieving health equity. Participants in this study were Iraqi refugee mothers who arrived in San Diego, California, five years from the beginning of the study in 2012.

Refugees who reported lower levels of educational attainment, increased financial strain, and a history of mental illness reported higher levels of acculturative stress. Surprisingly, those who reported higher levels of acculturative stress were more likely to seek out mental health services. Furthermore, those with a history of mental illness and those experiencing increased financial strain were more likely to report postponing care. Participants with lower levels of education were more likely to report being satisfied with the U.S healthcare system and having no preference regarding their doctors' race or ethnicity.

Acculturative Stress and Financial Strain

Refugees face many difficulties upon resettlement. Depending on the policies and laws of the host country, refugees are not able to work with the credentials they obtained in their countries of origin and work lower-paying jobs. Therefore, many refugees experience a decrease

in socioeconomic status and face increased financial burdens. Financial hardship leads to concerns about having enough money for food, medicine, and rent and is associated with poor health and psychological distress among refugee populations.[72,73]

Participants in this study who felt their financial needs were not being sufficiently met experienced higher levels of acculturative stress. These results suggest that financial resources may be a predictor of acculturative stress. Individuals of economically disadvantaged backgrounds do not have access to resources, services, and overall stability in their lives. Higher-paying job opportunities also decrease the financial burden individuals experience upon resettlement, reinforcing the stress-reducing effects of income and resources mentioned previously. On the other hand, people with fewer years of education are more likely to work in high-risk, low-paying jobs, threatening their health and financial stability.[74] It is crucial that refugees access services and engage in activities that encourage acculturation into the host community and acquisition of the host country's language, thus lessening the burden of acculturative stress.

Acculturative Stress and Level of Education

Due to the nature of the refugee process, refugees are often left without access to formal services and instructions, such as education. Studies have shown that higher levels of education facilitate refugees' integration into the host country, while lower levels of education are associated with separation and marginalization of refugees. Integration, separation, and marginalization are three of the four acculturative strategies identified by Berry and Sam.[40] A study conducted among Vietnamese Americans found that high levels of education predicted the Vietnamese Americans use of integration strategies which then predicted higher levels of self-esteem. Among the participants, those who had lived in the U.S for a shorter period of time, had

lower levels of education, did not attempt to partake in American culture, and focused more on participation in Vietnamese culture, were more likely to utilize marginalization and separation strategies and led to lower levels of self-esteem.[75] Results of another study conducted among Cambodian refugee women in New Zealand also found that women who were older, had lower levels of education, had lived shorter periods of time in New Zealand, and were of lower socioeconomic status, were less acculturated.[76]

This study found that higher levels of education were associated with lower levels of acculturative stress, which is consistent with previous research on other immigrant populations.[77] Education facilitates immigrants' ability to adapt to the host country's society, and thus it is a protective factor concerning acculturative stress and adverse mental health outcomes.[78,79] Individuals who completed fewer years of schooling reported higher acculturative stress levels than those who completed more years of education. Similarly, a study conducted by Ghaffarian among Iranian immigrants found that as the level of education increased, levels of cultural incorporation and cultural shift also increased. One explanation for this finding is that education helps open people's minds and makes them less resistant to cultural change through enhanced cultural incorporation, cultural shifts, and reduced cultural resistance.

Cultural incorporation refers to modifying cultural elements of the migrants' culture due to influence from the dominant culture. In contrast, cultural shift refers to absorbing new or unique practices or beliefs from the host community. Lastly, cultural resistance refers to opposing or not conforming to the dominant culture's traditions, beliefs, and values. These things occur through engagement with formal educational institutions, especially at the undergraduate and graduate levels.[80] Those who have completed higher levels of education have increased

employment opportunities, which bring new opportunities to access intellectual, financial, and social resources.[45]

Access to education and training for refugees is essential in allowing them to rebuild their livelihoods in their host countries. Zepinic et al. found that, among refugees from former Yugoslavia settled in the United Kingdom, Germany, and Italy, the most wanted forms of assistance included support in finding employment opportunities and further education and training. Furthermore, those with lower levels of education were more likely to report needing financial or material support. While those with higher levels of education wanted recognition for their qualifications and access to opportunities for higher education.[81] Overall, there is an established need to provide educational and employment opportunities to newly resettled refugees. As well as recognition of refugees' academic and employment credentials and qualifications. This will encourage inclusion of refugees, allowing them to pursue higher education and employment opportunities that correspond to their unique skill sets.

Acculturative Stress and Accessing Mental Healthcare

The sample in this study showed that those who experienced higher levels of acculturative stress were more likely to see a mental health specialist. These results align with Schubert et al.'s study, which aimed to test multiple psychosocial factors associated with help-seeking behavior in Russian, Somali, and Kurdish immigrants living in Finland. It was found that Russian immigrants who experienced previous traumatic events were more likely to experience mental health problems, leading to an increase in individuals seeking out healthcare services. [38] Among Kurdish immigrants, lower levels of acculturation were associated with higher levels of trauma and increased mental health problems. Kurdish immigrants experienced increased mental health symptoms, leading to increased help-seeking behaviors. [38] Individuals were experiencing

higher acculturative stress, indicative of low acculturation, and higher levels of psychological distress, leading them to seek out and access mental health services.

Alizadeh-Khoei et al. discuss the impact of acculturation and mental health on the use of health care services among elderly Iranian-born immigrants living in Australia. Unlike the current study, Alizadeh-Khoei et al. utilized language spoken at home, self-assessed English proficiency, and duration of residence in Australia to measure acculturation. As a result of increased psychological distress, elderly Iranian immigrants were limited in their ability to carry out physical activities without supervision, in greater need of help with carrying out daily activities, had poorer health status, and were less likely to use tertiary aged care services in comparison to their Australian counterparts. Acculturative stress is a predictor of psychological distress among immigrant populations.[82] Psychological distress resulting from decreased acculturation and increased acculturative stress leads to a decrease in health status and health services utilization.

While it may be expected that immigrants and refugees experiencing higher levels of acculturative stress would not utilize mental health services, they may find themselves in states of severe emotional suffering enough to seek semi-formal or formal treatment services. This study's results suggest that individuals experiencing higher levels of acculturative stress may seek opportunities to conform to the dominant culture's practices to decrease their feelings of distress and discomfort. In this case, exposure to formal mental health services may be an integrative intervention through the exposure of refugees to the clinic, healthcare professionals, language, and treatment modalities. This allows them to gain familiarity with cultural norms and customs, the environment, and institutions. Additionally, mental health counseling introduces patients to resilient coping mechanisms.

Seeking out a mental health specialist may be utilized by refugees in hopes of acculturating into the host country's community. Further establishing specialized mental health outreach services for refugees may help build trust and familiarity with health services, clarify refugee rights, and enable access to other mainstream services.[83] Therefore, increasing accessibility to culturally competent healthcare services will serve as a pathway to acculturation for refugees. Encouraging engagement with social institutions that understand refugees' situations will ease the burden and pressure to assimilate or blend in.

The participants in the study were Iraqi refugee mothers. Therefore, it is crucial to consider the impact the children's acculturation struggles may have on the mothers' decisions to seek out mental health care. Children of immigrants and refugees face an elevated risk of mental health problems and the burden of acculturating into the host country.[84,85] Acculturation can lead to behavioral, cognitive, and emotional changes among refugee children. As a result, in this study, refugee mothers experiencing elevated levels of acculturative stress in conjuncture with their children's acculturation struggles may be accessing mental health services to seek out coping mechanisms to help their children acculturate without difficulty. A study conducted among Asian immigrant adults and their children found that children of parents more accepting of the dominant culture were more likely to display higher social competence.[86]

It is important to note that participants who reported that they were not able to access a mental health specialist and those who claimed that they did not need to see a doctor for a mental health problem while significantly lower than those who sought out mental health services, were experiencing similar levels of acculturative stress. It would be expected that those who claimed that they did not need to see a mental health specialist would be experiencing much lower levels of acculturative stress than those who were not able to access mental health care. This suggests

that refugees may not recognize or be in denial over the severity of their mental health problems and the need to seek out mental health services. Additionally, refugees may fear the stigma they might receive from their community or healthcare providers upon disclosing their mental health struggles.[87]

Acculturative Stress and History of Mental Illness

Individuals with mental health problems may struggle with symptoms and disabilities due to the illness and the stereotypes and stigma surrounding mental illness. Consequently, people with mental illness face difficulties maintaining employment, safe and consistent housing, and adequate health care. Financial hardships, houselessness, and lack of health care services alone lead to poorer physical and mental health outcomes.[88] However, when an individual's legal status (i.e., refugee status) and mental illness are factored into the equation, their physical and psychological health worsens. This study indicates that individuals who reported a history of mental illness experienced higher levels of acculturative stress.

Refugees are an especially vulnerable population. Experiences of pre-and post-migration trauma, post-migratory stressors, the additional burden of resettling in a new country and possibly learning a new language, and a history of mental illness make the acculturation process of refugees unimaginably difficult and taxing, both mentally and physically. The relationship found in this study between high levels of acculturative stress and previous diagnosis of mental illness can be understood as a combination of these factors, which further increase the stress and vulnerability refugees experience upon resettlement. The fear of stigmatization and ostracization due to a diagnosis of mental illness is compounded by the fear of stigmatization due to refugee status and the difficulties of being a refugee.

Barriers to Medical Care

The healthcare sector plays a crucial role in the health, well-being, and quality of life of individuals. High-quality health services ensure early detection of illnesses and diseases, reduce the likelihood of premature death, and reduce disease burden. Unfortunately, adequate healthcare services and facilities are not readily available or accessible to everyone. People of uninsured, undocumented, economically disadvantaged, elderly, and racial and ethnic backgrounds are among the most vulnerable populations who struggle with accessing adequate and reliable healthcare. Research mainly examines barriers to mental health care utilization among refugees. A systematic review identified the most common barriers to accessing mental health services, including affordability issues, availability and accessibility of services, awareness of mental health, and stigma towards mental health.

Additionally, language, help-seeking behaviors, stigma, and negative attitudes towards and by providers were also common reasons for delaying care. [87] This study has established the relationship between higher levels of acculturative stress and increased financial stress. Thus, the relationship between financial strain and postponing care was investigated. Participants who postponed or delayed care were also more likely to report that their financial needs were poorly met.

These results align with Taylor et al.'s study that found that even though 75% of the 366 Iraqi refugees surveyed indicated having health insurance at the time of the survey, 43% of all participants reported delaying or not seeking care for a medical problem in the past 12 months. [89] The most common reason for postponing care was cost, especially among uninsured participants. Other reasons included the unavailability of a medical interpreter, lack of transportation, and lack of knowledge of the healthcare system. [89] Here, the relationship between financial hardships and

delaying medical care is evident. The inability to cover medical costs due to a lack of insurance or steady income leads to decreased access to primary and preventive medical services. Leading to higher rates of illness, disease, and premature death.

Relating to acculturative stress, the relationship between acculturative stress, financial stress, and delaying necessary healthcare is clear. High acculturative stress and increased financial instability lead to a delay in seeking care. Acculturative stress is exacerbated by economic instability. This instability leads to the inability to purchase and cover necessities, such as medical costs, further exacerbating the burden refugees experience during resettlement. This leads to poorer health outcomes, decreased productivity, and reduced ability to pursue educational and employment opportunities. These opportunities act as an introductory pathway into the host community. An inability to pursue such opportunities creates more stress due to being unable to properly integrate into the host country, perpetuating a never-ending cycle of stress.

Few studies have examined the effect of mental illness on accessing healthcare services among immigrant and refugee populations. Mental illness refers to conditions that affect individuals' cognitive, emotional, and behavioral capabilities.[90] Studies conducted among U.S adults have examined the association between the diagnosis of mental illness and accessing healthcare services. One study found that people with mental disorders were twice as likely to report being denied insurance because of a preexisting condition or concerned about losing their insurance. They were also twice as likely to delay seeking care due to cost and, in general, they were unable to obtain necessary medical care. This suggests that mental illness may be a barrier to accessing and maintaining needed medical care.[91]

Another study conducted by Thorpe et al. suggests that psychological distress due to mental illness is a barrier to preventive care services among elderly U.S adults. Those experiencing psychological distress were less likely to receive influenza vaccinations and annual dental check-ups. Distressed elderly women were less likely to receive a clinical breast examination.[92] These findings align with DiMatteo et al.'s study on understanding the effects of anxiety and depression on patient adherence. Patients experiencing depression are three times more likely to be non-compliant with medical treatment recommendations. Feelings of hopelessness, despair and reduced cognitive functioning due to depression make it difficult for patients to comply with their treatment or medication. Patients with depression will most likely withdraw or isolate themselves from their social or familial support systems, decreasing the number of support networks encouraging medication and treatment compliance.[93]

The current study found that participants who reported a history of mental illness more often reported postponing or not seeking medical care. Postponing care due to psychiatric conditions places patients in an even more vulnerable position. They are more at risk for developing other chronic conditions and cannot access valuable services and resources that aim to alleviate their mental health burden. Postponing or not seeking care is likely due to cost, lack of insurance, or self- or public stigmatization of mental health. Refugees with a history of mental illness may be apprehensive of receiving inadequate care by healthcare professionals due to implicit biases toward people with mental disorders and those with refugee status, further contributing to health disparities among already vulnerable populations.[94]

As discussed previously in this section, refugees reporting a history of mental illness are also more likely to experience higher levels of acculturative stress. This increased burden of having a mental illness and experiencing high acculturative stress levels leaves refugees facing

inconceivable challenges when attempting to adapt to their new communities. Mental illness and acculturative stress should be recognized and investigated further as barriers among refugees to receiving much-needed mental and somatic health care.

Level of Education and Healthcare Satisfaction and Treatment Preference

Given that there was a strong association between high levels of acculturative stress and lower levels of education, education was utilized to understand the attitudes and preferences of refugees towards health care services in the United States. Patient satisfaction is an important area of interest in healthcare because it can be used as an indicator for measuring the quality of health care.[95] This study found that participants with a lower level of education were more likely to be more satisfied with the U.S healthcare system. This difference in satisfaction may be because participants with a higher level of education are more likely to obtain a higher income and higher social status, leading individuals to have higher expectations of the care they receive, leading to increased dissatisfaction.[96,97] Additionally, this study also found that those with a lower level of education did not have a preference regarding their doctor's race or ethnicity. This may be because those with higher levels of education were most likely experiencing less financial stress and lower levels of acculturative stress. Therefore, they had the means and resources (i.e., money and time) to seek providers that align with their preferences. In comparison, those with a lower level of education are more worried about accessing care altogether.

The conceptual framework developed and discussed in this study aims to demonstrate the interconnectedness of acculturative stress and predictors of acculturative stress on refugees' ability to access healthcare services. These relationships can be seen as having a ripple effect on one another. Those of refugee status have an increased vulnerability to mental health problems

due to the many difficulties and stressors they face. Once resettled in their new host countries, they are met with a lack of resources and support. They are unable to work stable, high-paying jobs that provide health benefits due to a lack of language proficiency, lower levels of education, or loss of employment credentials (due to the loss of paperwork or certificates during the migration process or the inability to gain equivalency for credentials). This leads to an increase in financial burden here; refugees face stressors regarding financially meeting their basic necessities. This study has shown the impact level of education, and financial strain have on levels of acculturative stress. These burdens significantly affect refugees' ability or inability to adapt to their new cultural and social environments.

Next, this study investigated the association between participants' history of mental illness and levels of acculturative stress. Balancing both being of refugee status and having a history of mental illness, the participants face additional stressors, directly impacting their levels of acculturative stress. Additionally, these two factors (being a refugee and having a mental illness diagnosis) leave refugees feeling prone to discriminatory behaviors and attitudes from citizens of the host country. This, combined with the financial burdens and lower levels of education, places refugees in highly vulnerable positions.

This study also found that high levels of acculturative stress were associated with participants seeking mental health care services. There are mixed results in the existing literature regarding this relationship. Therefore, these results can be interpreted in a few different ways. Given the stigmatized nature of mental healthcare utilization, participants may not have wanted to disclose their need for the services or may not have been aware of the severity of their mental health problems. Additionally, of those who did seek out mental health services, it is possible that they were seeking ways to cope with heightened levels of acculturative stress. Additionally,

since the sample comprised of women who were mothers, it is possible that they were seeking mental health services in relation to their role as mothers. Motherhood may contribute to increased stress, resulting in the strong need for mental health services. However, being a mother may also be a motivating factor for participants to seek help in times of serious distress.

Limitations

Several limitations must be addressed in the current study. First, this study was conducted among a relatively small sample, which greatly decreases the ability to detect associations among variables in the sample. Second, the participants of this study only consisted of Iraqi refugee women living in El Cajon, California. Therefore, the results of this study are not generalizable to Iraqi refugee men or to other resettlement communities where host and refugee community characteristics may vary. Additionally, the ethnic makeup of El Cajon, consists mainly of Chaldean refugees who are Catholic. Hence, the levels of acculturative stress obtained in this study may not be reflective of the experiences of refugees living in pre-dominantly White communities.

The cross-sectional nature of this study is another limitation, which limits the ability to make causal inferences between predictors and outcomes and makes the interpretation of associations difficult. Additionally, the self-report nature of the data collected, and the measurement of exposure, outcome, and confounding variables simultaneously make the study susceptible to biases such as recall bias. Future studies should consider a prospective, longitudinal design to understand further the implications of acculturative stress on the development of mental health problems among refugee populations. Furthermore, future research should investigate the role of religious coping mechanisms on the development of acculturative stress.

CHAPTER 6 CONCLUSION

This study examined several aspects regarding acculturative stress and healthcare-seeking among Iraqi refugee women. Several associations were found between high levels of acculturative stress and increased financial strain, lower levels of education, history of mental illness, and accessing mental health services. Currently, there is little research investigating acculturative stress, specifically, as a barrier to accessing healthcare. Further research is needed to examine the specific acculturation experiences that hinder refugees' access to healthcare services. Targeted healthcare interventions and outreach toward refugees would greatly benefit their mental and physical health and well-being. There is also a need to increase cultural competency and humility among healthcare providers to provide refugee populations with responsive healthcare for their unique health needs while honoring their beliefs, customs, and values.[98] Upon resettlement in the U.S, refugees are faced with a fragmented refugee response that further exacerbates their symptoms of anxiety, depression, and PTSD. There is a need for refugee policy reform at the federal, state, and local levels to provide refugees with formal support for more extended periods of time upon initial resettlement. Without the proper resources and social support, formal and informal, refugees cannot increase their independence and self-sustainability, restore their dignity, and rebuild their lives. By providing refugees with the proper tools and giving them access to the services and facilities they need, they can acclimate to their new environments without carrying any additional burdens.

Table 1 Participant Characteristics (N = 213)

	N	M or %	Min	Max	SD
Age (years)		38.74	23.83	58.33	6.94
Age left Iraq (years)		33.05	13.50	52.75	7.27
Marital status					
Married	200	93.90%			
Not Married (separated, divorced, widowed)	13	6.1%			
Language spoken at home					
Chaldean	135	63.68%			
Arabic	72	33.96%			
Other	5	2.38%			
Religion					
Catholic	172	80.75%			
Muslim	32	15.02%			
Other	9	4.23%			
Education level					
No schooling	2	0.94%			
Elementary school	34	15.96%			
Middle school	51	23.94%			
High school	69	32.39%			
Trade or business school	33	15.49%			
Bachelor's degree or higher	24	11.27%			
Social status in Iraq [a]		5.50	1	10	2.60
Social status in US [a]		5.81	1	10	2.32
Financial status change [b]		1.58	1	3	0.80
Worse than before	132	61.97%			
About the same	39	18.31%			
Better than before	42	19.72%			
Ability to meet financial needs [c]		1.51	1	2	0.50
Poorly met	105	49.30%			
Well met	108	50.70%			
Acculturative stress		37.45	6.00	103.0	20.65

[a] Assessed using a ladder diagram of ten rungs, where the top rung represents the highest social status within the community and the bottom rung represents the lowest status

[b] Response options were 1 = doing worse financially in the U.S. than in Iraq; 2 = about the same; 3 = doing better financially in the U.S. than in Iraq.

[c] Response options were: 1 = poorly met, 2 = well met.

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