EXAMINATION OF HEALTH AND HUMAN SERVICES UTILIZATION AMONG CHALDEAN AMERICANS LIVING IN SOUTHEASTERN MICHIGAN

Veronica A. Kassab

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This is dedicated to the Chaldean community
living in Michigan and around the world.

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ABSTRACT

EXAMINATION OF HEALTH AND HUMAN SERVICES
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Chaldean Americans are a cultural group of local relevance in Southeastern Michigan. They are often grouped with other populations of Middle Eastern ancestry, preventing a specific understanding of their needs. The limited research that is available on the physical and mental health needs of Chaldean Americans points to their underutilization of health and human services and highlights cultural and contextual barriers to service accessibility and utilization (e.g., Dallo et al., 2011; Perkins et al., 2007). The purpose of this study was to explore hypotheses related to cultural responsiveness and general health beliefs on the utilization of medical and mental health services among Chaldean Americans. The perceived cultural responsiveness of services had a limited impact in predicting medical and mental health service utilization. There was also a trend for lower levels of perceived barriers to predict utilization of a medical service and for higher levels of perceived benefits to predict utilization of a mental health service. Overall, the greatest predictor of utilization of a medical service was having health insurance coverage, and the greatest predictor of utilization of a mental health service was reporting to have a mental health concern. Discussion focuses on the implications for research and practice in promoting service utilization among Chaldean Americans.

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CHAPTER I

INTRODUCTION

Chaldeans are an Iraqi ethnic group of relevance in Southeastern Michigan whose health and human service needs are poorly understood. One reason for the poor understanding of their needs is that researchers frequently include Chaldean Americans within samples of Arab Americans, preventing a thorough understanding of their specific health and human service needs (e.g., Abdulrahim & Baker, 2009; El-Sayed & Galea, 2009; Rice et al., 2006). Although broad cultural categories can be useful, they are problematic when there are meaningful differences among the groups that have been subsumed under them. For example, compared to Arab Americans, Chaldean Americans report significantly lower rates of depression (Jamil et al., 2008b) and higher rates of diabetes (Kridli, Herman, Brown, Fakhouri, & Jaber, 2005).

The limitations of broad cultural categories become especially problematic in the cases of cultural groups with a local relevance that exceeds their national impact. For example, while people of Chaldean ancestry account for less than one percent of the total population in the United States (U.S.), they are highly concentrated in specific localities of Southeastern Michigan where their impact on local social, economic, and political activities is notable (Sengstock, 2010; U.S. Census Bureau, 2003). As such, an understanding of health and human service needs that is responsive to Chaldeans Americans is of tremendous relevance in these localities.

Chaldeans in the United States

History and Immigration

Chaldeans are one of three closely related modern Assyrian groups that trace their cultural heritage back to the ancient cultures of Mesopotamia (Sengstock, 2010). These groups

share a common language that is related to ancient Aramaic, and despite closely overlapping cultures and histories they are distinguished primarily by their identification with one of three Christian denominations: the Chaldean Catholic Church, the Syriac Orthodox Church, and the Assyrian Church of the East. The members of these groups generally do not identify as Arab or Iraqi and instead utilize terms based on their specific Christian denomination as a unit of identity (i.e., Chaldean, Syriac, or Assyrian; Sengstock, 2010).

Chaldeans, Syriacs, and Assyrians have often been persecuted in Iraq (Hajjar, 2008; Sterling, 2008; U.S. Department of State, 2008). As a result, despite accounting for less than 10% of the Iraqi population, they account for the majority of Iraqi refugees (Sengstock, 2010). Although the largest concentrations of these refugees and their descendants are found in the U.S.—and in particular Southeastern Michigan—there are significant concentrations in Australia and Europe such that there are currently more Chaldeans, Syriacs, and Assyrians living in these areas than there are in their ancestral lands (Sengstock, 2010).

Immigration to the U.S. in general, and Michigan in particular, began around 1910 and coincides with the Assyrian Genocide, a mass slaughter of the Assyrian, Chaldean, and Syriac population of the Ottoman Empire during the First World War (Sengstock, 2010). After this initial influx, restrictions on immigration limited the number of arrivals through the mid 1960s. Beginning in 1968, when laws changed to allow more Iraqis to the U.S., there was a large and steady influx of immigrants that continued until the onset of the first gulf war (Sengstock, 2010). Although settlement to the U.S. temporarily stopped after the first gulf war, there has been continued growth in immigration after the invasion of Iraq in 2003, particularly as the destabilization of Iraq resulted in increased religious persecution and forced evacuation for Chaldeans, Syriacs, and Assyrians (U.S. Department of State, 2008). As of 2008, there are

estimated to be 90,000 Chaldeans, Syriacs, and Assyrians living in the U.S., with 60% of them living in the Midwest (U.S. Census Bureau, 2011).

The cultural, religious, and historical differences between Iraqi Arabs and Chaldeans, Syriacs, and Assyrians are reflected in their experiences and expectations as immigrants. Al-Rasheed (1994) documented differences between Iraqi Arabs and Iraqi Assyrians who had immigrated to London. Iraqi Arabs tended to still consider Iraq as their homeland and to aspire to return there after changes in the political climate. In contrast, Iraqi Assyrians tended to view their migration as permanent and to cut off contacts with Iraq. These findings were confirmed by Shoeb, Weinstein, and Halpern (2007), who found that none of the Chaldeans included in their sample of Iraqi refugees in Dearborn, Michigan entertained the idea of returning to Iraq. Despite strong connections to the U.S., Chaldeans referred to America as a "country" and Iraq as their "homeland". This suggests that among Chaldean, Syriac, and Assyrian immigrants the already complex process of cultural adaptation can be further complicated by the sense of permanently abandoning a native country without complete acceptance of the receiving country as a home (Shoeb et al., 2007).

Impact of Immigration and Acculturation on Physical and Mental Health

The stress of immigration and acculturation can have an impact on the physical and mental health of Chaldean Americans (e.g., Jamil et al., 2007), and the variegated immigration history of Chaldeans has important implications for the utilization of health and human services. Differing mental health patterns have been noted among Iraqi immigrants depending on their time of immigration (Jamil, Nassar-McMillan, & Lambert, 2007). In a sample of 350 Iraqi immigrants, including 141 Chaldeans, levels of post-traumatic stress disorder symptoms, anxiety, depression, and panic where assessed in three waves of immigrants: those who immigrated

before 1980, between 1980 and 1990, and post-1990 (Jamil et al., 2007). Jamil et al. (2007) found that the earlier immigration cohorts have significantly lower levels of anxiety, depression, and panic than the cohort that most recently immigrated. The authors of this study note that the reason for immigration between these groups is likely to have varied with the pre-1980 group likely immigrating for economic opportunity and the post-1990 group likely immigrating because of post-war effects, which may impact psychological distress and adjustment.

Due to the shifting social and political climate in Iraq, Iraqi immigrants have often experienced different levels of exposure to war, environmental stressors, and economic struggle in their home country. Their ease of immigration also varies with those immigrating prior to the Hussein regime being more likely to directly immigrate to the U.S. and those immigrating after Iraq's invasion of Kuwait or the Gulf Wars being more likely to spend a substantial amount of time in refugee camps in other Middle Eastern countries (Jamil et al., 2010). Pre-migration conditions are thought to influence post-migration well-being, which varies for those immigrating as refugees and those immigrating as non-forced displaced immigrants (Jamil et al., 2010). In a random sample of Arab and Chaldean Iraqi immigrants residing in southeastern Michigan, those immigrating after 1990 (post-Gulf War) had significantly poorer self-rated health compared to those immigrating before 1981 or between 1981 and 1991 (Jamil et al., 2010). This later immigrant cohort also had significantly higher proportions of psychosomatic and psychiatric disorders (e.g., sleep disturbance, chronic fatigue, depression). In path analyses, migration period was significantly related to exposure of environmental stressors and psychosomatic and psychiatric disorders, suggesting that immigrants who have sustained trauma and environmental stress following the 1991 Gulf War are at increased risk of psychosomatic and psychiatric disorders (Jamil et al., 2010). Additionally, post-migration stressors, such as

unemployment, are an important predictor of health and well-being. Those immigrating after 1991 have significantly higher unemployment rates, which is predictive of psychosomatic and psychiatric disorders (Jamil et al., 2010).

In addition to its mental illness correlates, immigration has several additional consequences of relevance for health and human services. Additional structural barriers faced by Chaldean immigrants include employment concerns and changes in socioeconomic status (Jamil et al., 2007). Rubin and Bhavnagri (2001) found that in addition to difficulties dealing with loss, separation, and adjustment to social norms, Chaldean adolescents in the U.S. face structural difficulties including language barriers. Chaldean American adolescents must also deal with numerous negative misconceptions held by White adolescents (e.g., group threat, xenophobia; Kumar, Seay, & Karabenick, 2011). These structural and social barriers add significantly to the tensions between identity, home, and the circumstances and past experiences in the native country (Shoeb et al., 2007).

Difficulty Estimating the Prevalence of Illness among Chaldean Americans

Despite the tendency for researchers to cluster Chaldean Americans with other groups of Middle Eastern ancestry, the available literature provides a cursory understanding of the physical and mental health concerns of Chaldean Americans and highlights important trends. First, as illustrated previously, patterns and correlates of health and illness often differ significantly between Chaldean Americans and other groups of Middle Eastern ancestry. In addition to the differences in diabetes (Kridli et al., 2005) and depression (Jamil et al., 2008b) noted earlier, existing studies have documented significant differences between Chaldean Americans and Arab Americans in tobacco use (Jamil et al., 2008c), chronic conditions (Jamil et al., 2009), and asthma (Jamil et al., 2011).

There is also evidence to suggest that some illnesses are grossly under-diagnosed among Chaldean Americans. For instance, in two different studies that used standardized medical measures (e.g., blood glucose testing) as the source of data, Kridli and colleagues (2005; 2006) found prevalence of diabetes among Chaldean Americans in the Detroit area of 44% and 63%, respectively. In contrast, in one study based on self-report of existing diagnosis of diabetes, Jamil and colleagues (2008a) found a prevalence of only 6% among a Chaldean sample in Southeastern Michigan. The stark differences in estimates of diabetes highlights that Chaldean Americans may be underutilizing health services leading to misdiagnosis of major medical concerns.

Service Utilization among Chaldean Americans

Some researchers have speculated that high prevalence rates of certain conditions (e.g., diabetes) among Chaldean Americans may be attributed to lack of access to or use of healthcare services (Kridli et al., 2005). Certainly, researchers have documented that Chaldean Americans are often underutilizing health and human services. For instance, Arkfen, Kubiak, and Farrag (2008) found that a mixed sample of Arab Americans and Chaldean Americans in Michigan accounted for a disproportionately small percentage of admissions to substance abuse treatment programs. The available research points to two influences driving underutilization among Chaldean Americans: (1) lack of perceived cultural responsiveness of services and (2) health beliefs that hinder service utilization.

Cultural Responsiveness

Researchers have often highlighted the cultural beliefs of Chaldean Americans—such as the avoidance of medical treatment out of fear of uncovering medical problems—as an important

factor influencing service underutilization (Kridli et al., 2005). Such explanations are consistent with the finding that recent immigrants are more likely to remain unengaged from health promotion or preventive care (Kridli, 2002). Additionally, the utilization of community services is impacted by the availability of services, knowledge of available services, and success in accessing such services. A qualitative study by Riggs et al. (2012) examined the experiences of refugee mothers in Australia, including 26 mothers of Iraqi/Assyrian-Chaldean descent (30% of sample Assyrian-Chaldean), and their utilization of cost-free government sponsored health services for mothers and children. Several mothers of Iraqi, Assyrian, and Chaldean descent discussed their unfamiliarity of the health services and were not connected to refugee mentors designed to support their access to early childhood services. Among those who had knowledge of the program, barriers to accessibility included limited English proficiency, which hindered their ability to make telephone calls and schedule appointments. Health agencies that employed an Arabic speaking liaison to make telephone calls to mothers noted increased utilization of services (e.g., fewer cancellations), a better understanding of services, and more trust in the services (e.g., increased openness to allowing nurses in the home). Iraqi, Chaldean, and Assyrian mothers who were aware of the program and accessed it successfully, reported satisfaction with the services and appreciated that services support the physical and emotional health of mothers as well as children, which was novel compared to services in their home country. This study suggests that when community services are promoted in a fashion that is responsive to the cultural and linguistic needs of Chaldeans, there is an increase in the utilization and satisfaction with services.

Even when community services are available and accessible to Chaldean Americans they are not always utilized. Perkins et al. (2007) examined the cultural and contextual factors that

influence underrepresented urban youth from participating in community youth programs (Chaldean sample *n* =13, 17%). Chaldean American youth involved in community youth programs in Southeastern Michigan shared reasons why their peers chose to participate in such programs. Reasons that facilitated participation included opportunities for social and peer support and to engage in positive influences, while subsequently avoiding dangerous influences. Factors that hindered participation included structural and familial barriers, such as lack of transportation and parental disapproval of involvement. Family involvement and protection of children were strong Chaldean values. Parents of Chaldean females were concerned about their daughters' interaction with males at the youth program, and Chaldean females were concerned for safety regarding the environment and location of the community center. Parents of Chaldean males in the study were also concerned about something "bad" happening to their sons if they participated in youth programs (e.g., negative peer influence). Although Chaldean youth in this study identified benefits of participating in community services, numerous cultural and contextual factors impacted their involvement.

Consistent with the findings of Riggs and colleagues (2012) and Perkins and colleagues (2007), scholars have suggested that culturally appropriate prevention and treatment programs would address the underutilization of health and human services by Chaldean Americans (Kridli et al., 2005). Engaging ethnic minority communities in services goes beyond matching an individual with a provider of the same ethnicity. In a meta-analytic study examining the impact of ethnic matching on mental health services, ethnic matching was not a clinically significant predictor of reducing dropout or improving utilization (Maramba & Nagayama Hall, 2002). Other researchers have suggested that responsiveness to cultural needs, such as understanding of

attitudes, beliefs, and expectancies, is more predictive of engagement and utilization of services (Zane et al., 2005).

Health Beliefs

Available research suggests that, across populations, health behavior and the utilization of health services are impacted by personal beliefs and perceptions (Becker, 1974). The Health Beliefs Model is a theory in health education and health promotion that examines the impact of the perceived benefits and the perceived barriers to engaging in health behavior (Becker, 1974). Researchers have uncovered that among Chaldean Americans the level of perceived barriers impacts utilization of health promotion services. In a study examining the rates of mammography screenings and attitudes and beliefs regarding mammography among Arab and Chaldean women in Michigan, Schwartz, Fakhouri, Bartoces, Monsur, and Younis (2008) found that the rates of having had a mammogram were lower among Middle Eastern women compared to the Michigan state average and compared to other ethnic minority groups in Michigan and nationally. Women who had never had a mammogram were more likely to have lower education levels, be unmarried, have no health insurance, be from Iraq, and live in the U.S. for less than 10 years compared to women who have had a mammogram. Middle Eastern women with a higher level of perceived barriers were significantly less likely to have ever had a mammogram than women with a lower level of perceived barriers. Specific barriers included negative attitudes and beliefs about receiving mammograms, such as "feeling funny," "it is embarrassing," and "will make me worry about cancer or breast cancer."

Other research has highlighted that interventions targeting perceived benefits positively impact the health service utilization of Chaldean Americans (Dallo, Zakar, Borrell, Fakhouri, & Jamil, 2011). Dallo and colleagues (2011) implemented a culturally-based cancer knowledge

intervention for Arab and Chaldean Americans in Michigan, which specifically promoted the benefits of cancer prevention and risk reduction strategies (Chaldean sample *n* = 229, 26.4%). Those with the greatest improvement in cancer knowledge had similar characteristics to those identified by Schwartz et al. (2008) who had never had a mammogram, including a lower education level, being unemployed, having lived in the U.S. for less than five years, and not having health insurance (Dallo et al., 2011). Taken together, findings from these studies suggest that utilization of health services among Chaldean Americans is low due to perceived barriers but that health education interventions that specifically focus on the benefits of services are more likely to be successful in engaging individuals with the greatest risk. Furthermore, work by Dallo et al. (2011) highlights that incorporation of culturally relevant material into health interventions improves the predictive value of positive health beliefs.

Conclusion and Goals

Chaldean Americans are often grouped with other populations of Middle Eastern ancestry, preventing a specific understanding of their needs. Although limited, the available research points to the underutilization of health and human services by Chaldean Americans and highlights cultural and contextual barriers to service accessibility and utilization (e.g., Dallo et al., 2011; Perkins et al., 2007). The purpose of this study was to explore the factors that facilitate or hinder the utilization of medical and mental health services among Chaldean Americans in southeastern Michigan. Based on the available literature, this study consisted of three goals:

(1) The first goal was to examine the perceived cultural responsiveness of a service provider in predicting utilization beyond the effect of cultural matching of a service provider.

(2) The second goal was to examine the perceived benefits of a service in predicting utilization beyond the perceived barriers to access.

(3) The third and exploratory goal was to compare the relative contributions of perceived cultural responsiveness to the more general health beliefs of benefits and barriers in predicting service utilization.

CHAPTER II

METHOD

Participants

Participants consisted of 162 Chaldean American adults who volunteered to complete a community survey, which was available in both English and Arabic, online or by paper and pencil. Survey participants were recruited through electronic and social media sources (e.g., email, Facebook, community listservs), as well as through snowball sampling techniques and word of mouth. In Table 1, there is a summary of the background characteristics of the community survey participants.

Table 1. *Community Survey Participant Characteristics*

Variable	*M* (*SD*)
% Completed on Paper	45
% Completed in Arabic	31
% Male	38
% Married	54
Age	39.62 (16.45)
% with at least High School Education	86
Cultural Group	
% Chaldean	91
% Assyrian	2
% Syriac	7

Note. $N = 162$.

Majority of participants completed the survey online (55%, $n = 89$) and in English (69%, $n = 112$). The average age of participants was 39 years ($SD = 16.45$), with a range of 18 to 81 years. Majority of participants were female (59%, $n = 95$) and married (54%, $n = 87$). In terms of highest level of education, 14% reported having less than a high school education ($n = 22$),

16% reported completing high school (*n* = 26), 17% reported completing some college (*n* = 27), 12% reported obtaining an associate's degree (*n* = 20), 24% reported obtaining a bachelor's degree (*n* = 39), 9% reported obtaining a master's degree (*n* = 14), and 9% reported obtaining a doctorate or other professional degree (*n* = 14). In relation to cultural identification, 91% identified as Chaldean (*n* = 147), 7% identified as Syriac (*n* = 12), and 2% identified as Assyrian (*n* = 3).

Table 2. *Community Survey Participant Immigration Characteristics*

Variable	Percentage
% Immigrated to U.S.	57
% Immigrated from Iraq	100
% Currently American Citizen	77
% Currently Permanent Resident	17
% Currently Refugee or Asylee	4

Note. Total sample: *N* = 162. Participants who had immigrated to the U.S.: *N* = 92.

Community survey participant immigration characteristics are described in Table 2. The majority of participants reported being foreign born and immigrating to the U.S. (57%, *n* = 92), with 100% of those immigrating having been born in Iraq. Year of immigration ranged from 1968 to 2013. The majority of the sample reported currently being an American citizen (77%, *n* = 124), 17% reported being a permanent resident (i.e., having a green card; *n* = 27), and 4% reported being a refugee or asylee (i.e., having a white card; *n* = 6).

Measures

Measures for this study were developed with input from a set of community professionals. The community professionals consisted of seven Chaldean American adults (5 female) who had experience working with Chaldean Americans in southeastern Michigan. They

represented multiple health and human service sectors including: non-profit organizations, mental health professionals/social workers, educators, religious organizations, medical professionals, and lay community residents. The community professionals provided feedback to the principal investigator on the types of questions included in the survey and provided strategies to recruit community survey participants. Following incorporation of the feedback from the community professionals, Executive Language Services, INC professionally translated all survey materials into Arabic. See Appendix A for certificate of professional translation.

Background Information

Survey participants completed a 20 item background questionnaire *(*appendices B and C) that asked participants to report their age, gender, ethnicity, marital status, number of children, number of people in household, current profession, country of origin, year of immigration, reason for immigration, generational status, legal status in U.S., highest level of education, language proficiency, socioeconomic status, and religious affiliation.

Study Variables

Survey participants completed a study variables questionnaire (appendices D and E) that that covered seven broad areas of service use. The questionnaire began with a section explaining the terms "medical health professional" and "mental health professional". Items were rated on a six-point likert scale ranging from *absolutely false (1)* to *absolutely true (6)*. Areas also included open-ended and forced choice (e.g., yes or no) questions.

Current Health Status. This area consisted of six items that asked participants to report any major medical or mental health concerns, whether they have regular health care providers and health insurance, and where they usually seek health care.

Identification of Available Services. The identification of available services area consisted of nine items that asked participants to rate whether there are enough services available to them and how they become aware of services. It also asked participants to identify services that are lacking in the Chaldean American community and provide suggestions for increasing awareness about available services.

Utilization of Services. The utilization of services area asked participants to indicate whether they have used a variety of services in the past 12 months, such as visited a medical doctor, visited an emergency room, been admitted to the hospital, visited a mental health professional, participated in a community program, and sought help from a religious leader. It also included open-ended questions regarding any other services utilized regularly and differences in service utilization for those who immigrated to the U.S.

Cultural Responsiveness. This area asked participants to rate the perceived cultural responsiveness of medical and mental health providers. Items included ratings of the importance of having a provider that understands personal culture, speaks the same language, and is from the same culture. It also included an open-ended question asking participants to identify aspects of Chaldean culture that are important to include in services.

Benefits to Service Utilization. This area included six items related to the perceived benefits of seeking medical and mental health care and open-ended questions related to personal factors that motivate service use. It also included open-ended questions asking participants to identify factors that motivate utilization of services.

Barriers to Service Utilization. This area included 10 items related to factors that hinder utilization of medical and mental health services, such as time, perceived importance, and

embarrassment. It also included open-ended questions asking participants to identify barriers to utilization of services.

Additional Factors that Impact Service Utilization. The final area consisted of 10 items related to confidence in seeking a service provider, cost, lack of knowledge about services, and comfort seeking mental health services.

Procedure

The community survey was available in English and Arabic through an online survey website, as well as by paper and pencil. A self-addressed and stamped envelope accompanied paper and pencil surveys, which were returned to the researcher. A cover letter accompanied the community survey, which explained the purpose of the study and the principal investigator's background. See Appendix F for cover letter in English and Arabic. Participants completed the survey anonymously and took approximately 20-30 minutes to complete. Survey participants had the option to enter to win one of 15, $25 gift cards sent electronically or through postal mail by providing an email address or street address. See Appendix G for the raffle entry form in English and in Arabic.

CHAPTER III

RESULTS

Preliminary Analyses

The correlations between background variables and outcome variables related to utilization of services, perceived cultural responsiveness of services, and perceived benefits and barriers to service utilization are summarized in Table 3. As can be observed, some background and outcome variables were significantly correlated with each other.

Utilization of a medical service in the past 12 months (e.g., visiting a medical doctor, urgent care, emergency room, being admitted to the hospital) was negatively associated with being male (r = -.18, p = .023) and positively associated with being married (r = .20, p = .012) and with higher ratings of the benefits of a medical service (r = .17, p = .038). Utilization of a mental health service in the past 12 months (e.g., visiting a mental health professional, seeking help from a religious leader, participating in a community program) was associated with being younger in age (r = -.24, p = .003), having a higher level of education (r = .26, p = .001), and being less likely to be foreign born (r = -.33, p = <.001). Those who had utilized a mental health service in the past 12 months also had higher ratings of the perceived benefits of mental health services (r = .22, p = .011). Those with medical insurance coverage were more likely to utilize a medical service in the past 12 months (r = .38, p = <.001) and have higher ratings of the benefits of medical (r = .38, p = <.001) and mental health services (r = .25, p = .004).

There were also several statistically significant correlations based on the survey language (i.e., English or Arabic) and survey format (i.e., online or paper/pencil) with several of the outcome variables. Those who took the survey in English were more likely to have visited a mental health professional in past 12 months (r = .27, p = .001), have higher ratings of the

benefits of medical (r = .48, p = <.001) and mental health (r = .45, p = <.001) services, and have higher ratings of barriers to accessing mental health services (r = .28, p = .001) compared to those who completed in the survey in Arabic. Completing the survey in English was also associated with lower ratings of the importance of having a medical (r = -.30, p = <.001) or mental health (r = -.27, p = .002) provider who are of the same culture. Those who completed the survey online were more likely to have utilized a mental health service in the past 12 months (r = .35, p = <.001) and have higher ratings of the benefits of medical (r = .39, p = <.001) and mental health (r = .33, p = <.001) services. Completing the survey online was also associated with lower ratings of the importance of having a medical (r = -.31, p = <.001) or mental health (r = -.27, p = .001) provider who are of the same culture compared to those who completed the survey on paper-pencil.

Overall, the importance of cultural matching of a provider was associated with demographic variables indicative of less acculturation. The importance of having a medical provider that is of the same culture was associated with being less likely to complete the survey in English (r = -.30, p = <.001) and online (r = -.31, p = <.001) and associated with being older (r = .26, p = .002), having a lower level of education (r = -.31, p = <.001), and being foreign born (r = .34, p = <.001). These demographic variables were not statistically significant for wanting a medical provider that understands culture. A similar pattern also followed for ratings of the importance of having a mental health provider of the same culture. Wanting a mental health provider that is of the same culture was negatively associated with completing the survey in English (r = -.27, p = .002) and online (r = -.27, p = .002) and associated with being older (r = .26, p = .003), not being an American citizen (r = -.20, p = .025), and being foreign born (r = .26, p = <.001). These demographic variables were not statistically significant for wanting a mental

health provider that understands culture. Furthermore, wanting a mental health provider that understands culture was negatively associated with being foreign born (r = -.18, p = .039).

Table 3. *Correlations of Background Characteristics and Measures*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1. English Survey	--																				
2. Online Survey	.74***	--																			
3. Age	-.43***	-.45***	--																		
4. Male	-.09	.01	-.01	--																	
5. Married	-.19*	-.21**	.56***	-.09	--																
6. American Citizen	.65***	.55***	-.09	-.08	-.03	--															
7. Education	.39***	.53***	-.40***	.12	-.25**	.20*	--														
8. Foreign Born	-.58***	-.62***	.51***	.06	.28***	-.45***	-.48***	--													
9. Insurance Coverage	.31***	.20*	.22**	-.13	.29***	.34***	.13	-.13	--												
10. Medical Concern	-.27**	-.27***	.52***	.09	.22**	-.09	-.30***	.22**	.11	--											
11. MH Concern	-.16*	-.19*	.31***	-.02	.12	-.09	-.12	.18*	.11	.30***	--										
12. Visited medical service in past 12 mo	.07	.12	.13	-.18*	.20*	.10	.02	-.05	.38***	.12	.06	--									
13. Visited MH service in past 12 mo	.27**	.35***	-.24**	-.02	-.15	.15	.26**	-.33***	.06	-.14	.14	-.01	--								
14. Medical provider that understands culture	-.03	-.13	-.01	.02	-.11	-.07	-.11	.13	-.01	-.01	.06	-.09	-.04	--							
15. Medical provider of the same culture	-.30***	-.31***	.26**	.18*	.08	-.16	-.31***	.34***	-.09	.23**	.16	-.01	-.15	.48***	--						
16. MH provider that understands culture	.17	.09	-.05	.13	-.15	.12	.19*	-.18*	.08	.03	.08	-.02	.15	.51***	.34***	--					
17. MH provider of the same culture	-.27**	-.27**	.26**	.17	.02	-.20*	-.13	.26**	-.14	.19*	.13	-.02	-.10	.45***	.80***	.51***	--				
18. Benefits of Medical Services	.48***	.39***	.04	-.11	.02	.50***	.24**	-.22**	.38***	.13	.11	.17*	.17*	.04	-.09	.14	-.04	--			
19. Benefits of MH Services	.45***	.33***	.07	-.12	.04	.45***	.23**	-.21*	.25**	-.00	.09	.08	.22*	.01	-.02	.16	.07	.70***	--		
20. Barriers of Medical Services	.12	.02	-.09	.06	.04	-.00	-.06	-.06	.03	-.01	-.01	-.15	.08	.09	.23**	.32***	.26**	-.13	-.11	--	
21. Barriers of MH Services	.28**	.10	-.17	.07	-.02	.07	.10	-.21*	.16	-.09	-.09	-.10	.11	.06	.12	.42***	.20*	.06	.12	.77***	--

Note. English = 1, Arabic = 0. Online = 1, Paper-Pencil = 0. Male = 1, Female = 0. Married =1, Single = 0. Born outside of U.S. = 1, Born in U.S. = 0. American citizen = 1, non-American citizen = 0. Yes = 1, No = 0. *p < .05. **p < .01. *** p <.001.

Goal One

The first goal of the study was to examine the perceived cultural responsiveness of a service provider in predicting utilization of a service beyond the effect of cultural matching of a service provider.

Impact of a Culturally Responsive Medical Provider on Service Utilization

A hierarchical logistic regression was conducted to examine the perceived cultural responsiveness of a provider in predicting utilization of medical service in the past 12 months beyond the impact of having a medical provider of the same culture. A medical service included visiting a medical doctor for a check-up or annual exam, visiting an emergency room or urgent care, or being admitted to the hospital.

The first step of the analysis examined survey factors (i.e., language and format in which survey was completed) and demographic variables associated with utilization of a medical service and with other predictor variables in the model. The analysis was statistically significant, indicating that the survey factors and demographic variables together make a significant contribution in predicting utilization of a medical service ($\chi^2(7) = 25.84$, $p = .001$). After controlling for all other survey factors and demographic variables, having medical insurance and having a post secondary education (i.e., some college or associate's, bachelor's, master's, or doctorate degree) remained statistically significant predictors of utilizing a medical service. The likelihood of those with health insurance to utilize a medical service in the past 12 months was 10 times greater compared to those without health insurance (Exp(B) = 10.05, $p = .001$). Those with post secondary education had a 75% decrease in the likelihood of utilizing a medical service in the past 12 months compared to those with a high school education or less (Exp(B) = 0.25, $p = .042$).

The second step of the analysis examined the impact of cultural matching in predicting utilization of a medical service. The analysis was statistically significant ($\chi^2(8) = 25.92$, $p = .001$). After controlling for all other variables in the model, having medical insurance and having a post secondary education remained statistically significant predictors of utilizing a medical service. At this level of analysis, those with health insurance were 10 times more likely to utilize a medical service in the past 12 months compared to those without health insurance (Exp(B) = 10.19, $p = .001$). Those with a post secondary education had a 76% decrease in the likelihood of utilizing a medical service in the past 12 months compared to those with a high school education or less (Exp(B) = 0.24, $p = .042$). The importance of having a medical provider of the same culture was not a statistically significant predictor of utilizing a medical service (Exp(B) = 0.96, $p = .776$).

Table 4. *Summary of Final Model of Logistic Regression Analysis - Impact of Cultural Responsiveness in Predicting Utilization of a Medical Service in the Past 12 Months*

Variable	*B*	*SE*	*OR*	95% CI	Wald Statistic	*p*
Step 1						
English Survey	-1.06	0.92	0.35	[0.06, 2.10]	1.33	.248
Online Survey	0.93	0.82	2.53	[0.51, 12.59]	1.28	.257
Age	0.00	0.02	1.00	[0.96, 1.05]	0.00	.976
Post Secondary Education	-1.37	0.72	0.26	[0.06, 1.05]	3.57	.059
Foreign Born	-0.80	0.77	0.45	[0.10, 2.02]	1.09	.298
Health Insurance Coverage	2.38	0.70	10.77	[2.75, 42.23]	11.63	.001
Major Medical Concern	1.04	0.94	2.82	[0.45, 17.83]	1.21	.271
Step 2						
Medical Provider of Same Culture	0.20	0.18	1.02	[0.72, 1.45]	0.01	.912
Step 3						
Medical Provider who Understands Culture	-0.18	0.22	0.84	[0.55, 1.28]	0.67	.413

Note. CI = confidence interval for odds ratio (OR).

The final step of the analysis examined the impact of the cultural responsiveness of a medical provider on utilization of a medical service in the past 12 months over and above the impact of survey and demographic variables and cultural matching. The summary of results from the final regression model is presented in Table 4. The analysis was statistically significant ($\chi^2(9) = 26.63$, $p = .002$). After controlling for all other variables in the model, the importance of having a medical provider who understands personal culture (Exp(B) = 0.84, $p = .413$) was not a statistically significant predictor of service utilization. In the final model, the only statistically significant predictor of utilizing a medical service in the past 12 months remained having health insurance. After controlling for all other variables, those with health insurance were almost 11 times more likely to utilize a medical service compared to those without health insurance (Exp(B) = 10.77, $p = .001$).

Impact of a Culturally Responsive Mental Health Provider on Service Utilization

A hierarchical logistic regression was conducted to examine the perceived cultural responsiveness of a provider in predicting utilization of a mental health service in the past 12 months beyond the impact of having a mental health provider of the same culture. A mental health service included visiting a mental health professional, participating in a community program, and seeking help from a religious leader.

The first step of the analysis examined survey factors (i.e., language and format in which survey was completed) and demographic variables associated with utilization of a mental health service and with other predictor variables in the model. The analysis was statistically significant, indicating that the survey factors and demographic variables together make a significant contribution in predicting utilization of a mental health service ($\chi^2(7) = 29.24$, $p = <.001$). After controlling for all other survey factors and demographic variables, reporting a mental health

concern remained a statistically significant predictor of utilizing a mental health service. Those who reported having a major mental health concern were five times more likely to utilize a service compared to those who did not report having a major mental health concern (Exp(B) = 5.64, p = .009).

The second step of the analysis examined the impact of cultural matching in predicting utilization of a mental health service. The analysis was statistically significant ($\chi^2(8) = 29.24$, p = <.001). After controlling for all other variables in the model, reporting a mental health concern continued to be a statistically significant predictor of utilizing a service. At this level of analysis, those who reported having a major mental health concern were five times more likely to utilize a service compared to those who did not report having a major mental health concern (Exp(B) = 5.63, p = .010). The importance of having a mental health provider of the same culture was not a statistically significant predictor of utilizing a service (Exp(B) = 1.01, p = .963).

Table 5. *Summary of Final Model of Logistic Regression Analysis - Impact of Cultural Responsiveness in Predicting Utilization of a Mental Health Service in the Past 12 Months*

Variable	*B*	*SE*	*OR*	95% CI	Wald Statistic	*p*
Step 1						
English Survey	0.31	0.71	1.37	[0.34, 5.44]	0.20	.659
Online Survey	0.75	0.64	2.12	[0.61, 7.41]	1.38	.240
Age	0.00	0.02	1.00	[0.97, 1.04]	0.00	.985
Post Secondary Education	0.64	0.54	1.90	[0.66, 5.48]	1.40	.236
Foreign Born	-0.80	0.59	0.45	[0.14, 1.43]	1.83	.176
Health Insurance Coverage	-0.39	0.62	0.68	[0.20, 2.26]	0.40	.526
Major Mental Health Concern	1.68	0.67	5.39	[1.46, 19.85]	6.40	.011
Step 2						
Mental Health Provider of Same Culture	-0.09	0.15	0.91	[0.67, 1.23]	0.38	.539
Step 3						
Mental Health Provider who Understands Culture	0.19	0.18	1.21	[0.86, 1.71]	1.17	.279

Note. CI = confidence interval for odds ratio (OR).

The final step of the analysis examined the impact of the cultural responsiveness of a mental health provider on utilization of a mental health service in the past 12 months over and above the impact of survey and demographic variables and cultural matching. The summary of results from the final regression model is presented in Table 5. The analysis was statistically significant ($\chi^2(9) = 30.42$, $p = <.001$). After controlling for all other variables in the model, the importance of having a mental health provider who understands personal culture (Exp(B) = 1.21, $p = .279$) was not a statistically significant predictor of service utilization. In the final model, the only statistically significant predictor of utilizing a mental health service in the past 12 months remained having a major mental health concern. After controlling for all other variables, those with a major mental health concern were five times more likely to utilize a mental health service compared to those without a major mental health concern (Exp(B) = 5.39, $p = .011$).

Goals Two and Three

The second goal of the study was to examine the perceived benefits of a service in predicting utilization beyond the perceived barriers to access. The third and exploratory goal was to compare the relative contributions of perceived cultural responsiveness to the more general health beliefs of benefits and barriers in predicting service utilization.

Predicting Utilization of a Medical Service

A hierarchical logistic regression was conducted to examine the perceived benefits of a medical service in predicting utilization in the past 12 months beyond the perceived barriers to accessing a medical service. The first step of the analysis examined survey factors (i.e., language and format in which survey was completed) and demographic variables associated with utilization of a medical service and with other predictor variables in the model. The analysis was

statistically significant, indicating that the survey factors and demographic variables together make a significant contribution in predicting utilization of a medical service ($\chi^2(7) = 25.34$, $p = .001$). After controlling for all other survey factors and demographic variables, having medical insurance and having a post secondary education (i.e., some college or associate's, bachelor's, master's, or doctorate degree) remained statistically significant predictors of utilizing a medical service. The likelihood of those with health insurance to utilize a medical service in the past 12 months was 10 times greater compared to those without health insurance (Exp(B) = 10.33, $p = .001$). Those with post secondary education had a 75% decrease in the likelihood of utilizing a medical service in the past 12 months compared to those with a high school education or less (Exp(B) = 0.25, $p = .042$).

The second step of the analysis examined the impact of the perceived barriers and benefits to seeking medical services on utilization. The analysis was statistically significant ($\chi^2(9) = 28.81$, $p = .001$). After controlling for all other variables in the model, having medical insurance and having a post secondary education remained statistically significant predictors of utilizing a medical service. At this level of analysis, those with health insurance were 10 times more likely to utilize a medical service in the past 12 months compared to those without health insurance (Exp(B) = 10.46, $p = .001$). Those with a post secondary education had a 74% decrease in the likelihood of utilizing a medical service in the past 12 months compared to those with a high school education or less (Exp(B) = 0.26, $p = .051$). The perceived barriers to accessing medical services approached statistical significance for prediction of utilizing a medical service. This trend suggests that for every one-point increase in the perceived barriers to accessing medical services, there was a 35% decrease in the likelihood of utilizing a medical

service (Exp(B) = 0.65, p = .074). The perceived benefits of medical services was not a statistically significant predictor of utilization (Exp(B) = 1.00, p = .983).

Table 6. *Summary of Final Model of Logistic Regression Analysis Predicting Utilization of a Medical Service in the Past 12 Months*

Variable	*B*	*SE*	*OR*	95% CI	Wald Statistic	*p*
Step 1						
English Survey	-0.71	1.08	0.49	[0.06, 4.09]	0.43	.513
Online Survey	0.63	0.83	1.88	[0.37, 9.48]	0.58	.445
Age	0.00	0.03	1.00	[0.95, 1.05]	0.00	.994
Post Secondary Education	-1.22	0.73	0.29	[0.07, 1.24]	2.79	.095
Foreign Born	-0.89	0.80	0.41	[0.09, 1.97]	1.24	.265
Health Insurance Coverage	2.45	0.75	11.62	[2.68, 50.37]	10.73	.001
Major Medical Concern	0.59	0.98	1.80	[0.26, 12.32]	0.36	.547
Step 2						
Barriers to Medical Services	-0.49	0.26	0.62	[0.37, 1.03]	3.42	.065
Benefits to Medical Services	-0.03	0.34	0.97	[0.50, 1.89]	0.01	.931
Step 3						
Medical Provider of Same Culture	0.14	0.19	1.15	[0.79, 1.67]	0.52	.472
Medical Provider who Understands Culture	-0.23	0.23	0.79	[0.51, 1.24]	1.04	.309

Note. CI = confidence interval for odds ratio (OR).

The final step of the analysis examined the impact of the cultural responsiveness of a medical provider on utilization of a medical service in the past 12 months over and above the impact of survey and demographic variables and the perceived benefits and barriers to accessing medical services. The summary of results from the final regression model is presented in Table 6. The analysis was statistically significant ($\chi^2(11) = 30.02$, p = .002). After controlling for all other variables in the model, the importance of having a medical provider who is of the same culture (Exp(B) = 1.15, p = .472) and the importance of having a medical provider who understands personal culture (Exp(B) = 0.79, p = .309) were not statistically significant

predictors of utilization of a medical service. In the final model, the only statistically significant predictor of utilizing a medical service in the past 12 months remained having health insurance. After controlling for all other variables, those with health insurance were over 11 times more likely to utilize a medical service compared to those without health insurance (Exp(B) = 11.62, p = .001).

Predicting Utilization of a Mental Health Service

A hierarchical logistic regression was conducted to examine the perceived benefits of a mental health service in predicting utilization in the past 12 months beyond the perceived barriers to accessing a mental health service. The first step of the analysis examined survey factors and demographic variables associated with utilization of a mental health service and with other predictor variables in the model. The analysis was statistically significant, indicating that the survey factors and demographic variables together make a significant contribution in predicting utilization of a mental health service ($\chi^2(7) = 24.34$, p = .001). After controlling for all other survey factors and demographic variables, having a major mental health concern remained a statistically significant predictor of utilizing a mental health service. Those who reported having a major mental health concern were five times more likely to utilize a mental health service compared to those who did not report having a major mental health concern (Exp(B) = 5.42, p = .014).

The second step of the analysis examined the impact of the perceived barriers and benefits to seeking mental health services on utilization. The analysis was statistically significant ($\chi^2(9) = 28.07$, p = .001). After controlling for all other variables in the model, having a major mental health concern remained a statistically significant predictor of utilizing a mental health service. Those who reported having a major mental health concern were five times more

likely to utilize a mental health service compared to those who did not report having a major mental health concern (Exp(B) = 5.12, p = .021). The perceived barriers to accessing mental health services was not a statistically significant predictor of utilization (Exp(B) = 1.03, p = .863). The perceived benefits to accessing mental health services approached statistical significance for prediction of utilizing a mental health service. This trend suggests that for every one-point increase in the perceived benefits to accessing mental health services, there was almost a two times great likelihood of utilizing a mental health service (Exp(B) = 1.60, p = .063).

The final step of the analysis examined the impact of the cultural responsiveness of a mental health provider on utilization of a mental health service in the past 12 months over and above the impact of survey factors and demographic variables and the perceived barriers and benefits to accessing mental health services. The summary of results from the final regression model is presented in Table 7. The analysis was statistically significant ($\chi^2(11) = 29.51$, p = .002). After controlling for all other variables in the model, the importance of having a mental health provider who is of the same culture (Exp(B) = 0.85, p = .342) and the importance of having a mental health provider who understands personal culture (Exp(B) = 1.25, p = .269) were not statistically significant predictors of utilization of a mental health service. In the final model, the only statistically significant predictor of utilizing a mental health service in past 12 months was having a major mental health concern. Those who reported having a major mental health concern were almost five times more likely to utilize a mental health service compared to those who did not report having a major mental health concern (Exp(B) = 4.91, p = .026).

Table 7. *Summary of Final Model of Logistic Regression Analysis Predicting Utilization of a Mental Health Service in the Past 12 Months*

Variable	*B*	*SE*	*OR*	95% CI	Wald Statistic	*p*
Step 1						
English Survey	-0.43	0.81	0.65	[0.13, 3.17]	0.28	.595
Online Survey	0.75	0.68	2.12	[0.56, 8.08]	1.22	.270
Age	-0.01	0.02	0.99	[0.95, 1.03]	0.23	.630
Post Secondary Education	0.59	0.57	1.81	[0.59, 5.50]	1.08	.299
Foreign Born	-0.70	0.63	0.50	[0.15, 1.70]	1.24	.266
Health Insurance Coverage	-0.25	0.64	0.78	[0.22, 2.70]	0.16	.692
Major Mental Health Concern	1.59	0.71	4.91	[1.21, 19.91]	4.97	.026
Step 2						
Barriers to Mental Health Services	0.00	0.19	1.00	[0.69, 1.46]	0.00	.985
Benefits to Mental Health Services	0.50	0.25	1.58	[0.97, 2.59]	3.30	.069
Step 3						
Mental Health Provider of Same Culture	-0.16	0.17	0.85	[0.62, 1.18]	0.90	.342
Mental Health Provider who Understands Culture	0.22	0.20	1.25	[0.84, 1.85]	1.22	.269

Note. CI = confidence interval for odds ratio (OR).

CHAPTER IV

DISCUSSION

Chaldean Americans are a cultural group of local relevance in Southeastern Michigan who have often been grouped with other populations of Middle Eastern ancestry, preventing a specific understanding of their needs. The limited research on the physical and mental health needs of Chaldean Americans points to the underutilization of health and human services and highlights cultural and contextual barriers to service accessibility and utilization (e.g., Dallo et al., 2011; Perkins et al., 2007). This study had three goals: (1) to examine the perceived cultural responsiveness of a service provider in predicting utilization beyond the effect of cultural matching, (2) to examine the perceived benefits of a service in predicting utilization beyond the perceived barriers to access, and (3) to explore the relative contributions of perceived cultural responsiveness to the more general health beliefs of benefits and barriers in predicting service utilization. The importance of cultural matching and cultural responsiveness played a very limited role in predicting medical or mental health service utilization. The perceived barriers and benefits of services played different roles in predicting utilization depending on the type of service. There was a trend toward statistical significance for lower levels of perceived barriers to predict great medical service utilization, and a trend toward statistical significance for higher levels of perceived benefits to predict greater mental health service utilization. Overall, the greatest predictor of utilizing a medical service was having health insurance coverage, and the greatest predictor of utilizing a mental health service was reporting to have a mental health concern. Discussion is focused on the implications for research and practice with Chaldean Americans for each of the study goals.

Goal One: Cultural Responsiveness of Service Providers

The importance of having a service provider that is of the same culture or that understands personal culture were not statistically significant predictors of utilization of services among this sample of Chaldean Americans. Other researchers have documented the importance of cultural responsiveness in engaging minority communities in health services (Sue, Fujino, Hu, Takeuchi, David, & Zane, 1991; Zane et al., 2005). Lack of significant findings in the current study may be attributed to the accuracy and measurement of cultural responsiveness factors. Future research with Chaldean Americans would benefit from specific measurement of cultural responsiveness factors beyond simply cultural match or cultural understanding. Additional cultural responsiveness items might examine perceptions of personal culture being incorporated in treatment, a provider respecting personal culture, or a provider discussing cultural implications in making treatment decisions. Additionally, future research might examine the impact of English language proficiency and level of acculturation as factors that attenuate the relationship between cultural responsiveness or cultural matching of providers and service utilization. Researchers have documented that ethnic and language match of service providers is predictive of length and outcome of mental health services only for clients whose primary language is not English (Sue et al., 1998).

If future research conducted with more accurate measurement reveals a significant impact of cultural responsiveness on service utilization, there may be important implications for practice with Chaldean Americans. Implications for practice at this time are tentative and based on past research that suggests there are aspects of Chaldean culture and local community qualities that service providers may consider accommodating to improve clinical practice. One such area is the high level of stigma associated with utilizing mental health services and fear of breaches in

privacy and confidentiality within the Chaldean American community (Hakim-Larson, Kamoo, Nassar-McMillan, & Porcerelli, 2007). Likely, this concern stems from perceptions of the Chaldean community in Michigan being interconnected and tight-knit posing increased risk of personal information being shared. The need to have in place and reiterate to clients strict privacy and confidentiality measures may be even more vital for Chaldean providers, who may be seen as directly linked to the community and with privileged information. Beyond having trust in the ethical practices of providers to ensure confidentiality, providers that serve Chaldean Americans for sensitive matters (e.g., mental health, sexual concerns) may benefit from having structural changes in their offices to ensure that privacy is maintained in waiting rooms and treatment rooms. Service organizations that take into consideration the needs of local communities and establish culturally competent practices for governance (i.e., policies, procedures) and structure (e.g., location, intake process) are more likely to improve the accessibility and utilization of services (Acevedo-Polakovich, Crider, Kassab, & Gerhart, 2011).

Goal Two: Benefits and Barriers to Service Utilization and Accessibility

With regards to medical services, the greatest predictor of utilization for Chaldean Americans was having health insurance coverage. Those with health insurance were over 11 times more likely to have utilized a medical service in the past 12 months than those without health insurance. This finding is similar to other research findings that those who are insured utilize more medical services than those who are uninsured (Ezzati-Rice & Rohde, 2008; Kashihara & Carper, 2009). Implications for practice include service providers taking steps to provide information about enrollment in health insurance plans to Chaldean American patients, which may lead to greater utilization of medical services by Chaldean Americans and decreased perception of barriers in accessing medical services.

Being uninsured and the cost of medical services are common barriers to utilizing medical services. Relatedly, increased perception of barriers to services led to a 38% decrease in utilization of medical services, which was a finding that approached statistical significance. This finding is similar to that found by Schwartz et al. (2008) where Middle Eastern women in Michigan who had higher levels of perceived barriers were less likely to have ever had a mammogram than women with a lower level of perceived barriers. As the findings in the current study only approached statistical significance, future research is needed to confirm and expand upon the impact of perceived barriers in utilizing medical services. Future research should examine the specific barriers that hinder utilization of medical services among Chaldean Americans to determine the role health insurance coverage plays in prediction over and above the impact of other systemic barriers, such as limited English proficiency, lack of transportation, and distance to provider. Additionally, future research would benefit from examination of other aspects of the Health Beliefs Model (Becker, 1974) in predicting utilization of a medical service, including the perceived susceptibility and seriousness of an illness.

With regards to utilizing mental health services, the greatest predictor was reporting having a mental health concern. Those with mental health concerns were almost five times more likely to utilize a mental health service than those who did not report having a mental health concern. Given past research related to the inefficiencies of estimating prevalence of an illness based on self-report versus a standardized measure (e.g., Kridli et al., 2005; Jamil et al., 2008a), this result suggests the need to increase awareness in identifying mental health symptoms among Chaldean Americans in order to promote service utilization. Future research would benefit from examining the prevalence and severity of common mental health conditions using validated research measures, such as the Hamilton Depression Rating Scale (Hamilton, 1960) or the

Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995). Use of a multi-item measure may increase the accuracy of detecting Chaldean Americans with mental health symptoms, especially given cultural stigma and fear of shame and dishonor associated with acknowledging mental illness among Arab and Chaldean populations (Hakim-Larson et al., 2007). The use of multi-item symptom measures also has implications for clinical practice as it may give Chaldean Americans a reference for the severity of their symptoms and provide justification for seeking professional care, as Chaldean Americans are more likely to reserve professional mental health care for more severe instances that cannot be resolved with personal measures (i.e., help from family, friends, religious leaders).

Efforts to promote mental health awareness and mental health services among Chaldean Americans would likely be more successful if focused on the benefits of mental health care. An increase in the perceived benefits of mental health services led to almost a two times great likelihood of utilizing a mental health service, which is a result that approached statistical significance. Hakim-Larson et al. (2007) cites recommendations for mental health clinicians to overcome barriers in treatment with Chaldean American families and notes the need to reduce focus on diagnostic labels such as "depression" and instead focus on the positive benefits of mental health services, such as gaining family happiness, peace, and harmony. As the findings in the current study only approached statistical significance, future research is needed to confirm and expand upon the impact of perceived benefits in utilizing mental health services.

Taken together, efforts to promote utilization of medical and mental health services among Chaldean Americans may require different approaches. Promotion of medical services may be more fruitful if focused on reducing barriers, such as lack of health insurance coverage. Promotion of mental health services may be more fruitful if focused on the benefits of helping to

uncover a need (i.e., recognizing a mental health concern). This pattern of results in utilization of medical and mental health services suggests that Chaldean Americans are aware of the seriousness of medical illness and the benefits of accessing medical services; however, structural and systemic barriers hinder their utilization. It also suggests that Chaldean Americans positively view mental health services but that a gatekeeper to utilization is acknowledgement of a having a mental health concern.

Goal Three: Exploration of Cultural Responsiveness and General Health Beliefs

The third goal of the study was to explore the relative contributions of perceived cultural responsiveness to the general health beliefs of benefits and barriers in predicting service utilization among Chaldean Americans. Among this sample of Chaldean Americans, there were no statistically significant results for the impact of cultural matching of a service provider or the perceived cultural responsiveness of service provider in predicting utilization of medical or mental health services. Given this pattern of results, the third goal of the study was not fully unexplored, as the relative contributions of cultural responsiveness and general health beliefs could not be accurately compared. Future research conducted with more accurate measurement of cultural responsiveness factors, as previously discussed, may be better able to ascertain the relative contributions of cultural responsiveness and general health beliefs in predicting service utilization among Chaldean Americans.

Limitations

The findings of this study must also be considered with light to its limitations. Although conducted with community participation and providing surveys in Arabic and English, online and paper-pencil, there was still limited recruitment of participants who had varying

backgrounds, in particular a limited a sample of refugees and newly arrived immigrants. Additionally, there were no participants who completed the survey online in Arabic, suggesting that the younger, Arabic speaking sector of Chaldean Americans was unreached. Future research might take steps to identify a key informant who can promote research participation among younger, Arabic speaking Chaldean Americans through social media.

Furthermore, this study was limited in its recruitment of participants who identified having a major medical and/or mental health concern and having visited a mental health professional, which likely impacted strength of statistical analyses in predicting service utilization. Given stigma among Chaldean Americans in disclosing personal concerns, future research might utilize checklists of common medical and mental health concerns rather than a yes-no and open-ended question, which requires participants to specify their personal concern. Additionally, this research was conducted using proxies of acculturation (e.g., being foreign born, citizenship status, generational status). Future research might examine the impact of measures of acculturative stress on the development of physical and mental health concerns and utilization of services.

Conclusion

Despite its limitations, the study provides insight into the predictors of utilization of medical and mental health services among Chaldean Americans, an understudied group of local relevance. Findings from this study begin to shed light on the systemic and cultural factors that impact service utilization. By beginning to understand patterns of service utilization among Chaldean Americans, future research and practice can work to promote service utilization in a culturally responsive manner.

APPENDICES

APPENDIX A

CERTIFICATE OF PROFESSIONAL TRANSLATION

EXECUTIVE LANGUAGE SERVICES, INC.

-Rita Denha-
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SS
COUNTY OF OAKLAND)

I, AGHAD RAZOKI, hereby certify and attest that I am fluent in **ARABIC/ENGLISH** and am competent to translate documents in both languages and that the above attached is the true and accurate translation of the document(s) to the best of my knowledge and ability.

DATED: 5/22/2013

TRANSLATION OF:
Dissertation of mental and medical health FOR Veronica Kassab

Aghad Razoki

As it has been requested by the department, hereunto to provide my home address and phone number. Please be advised that I do not make this of public record.
If you need to contact me regarding the translation herein you may contact EXECUTIVE LANGUAGE SERVICES, INC., at the above address and phone number.

Subscribed and sworn to before me this
22 Day May, 2013

Notary Public, AHLAM Y. DENHA
Oakland County, State of Michigan
My Comm. Ex: 12/10/2017
Note: I hereby attest the attached document is a true exact, complete, and unaltered photo copy of the original.

APPENDIX B

BACKGROUND INFORMATION

Please answer the following questions regarding your personal background. Your responses will be kept private and will never be associated with a name.

1. Age (in years): _____

2. Gender: Male Female

3. What is your race or origin? You may choose one or more.
   a. White or Caucasian
   b. Black or African American
   c. Latina/o or Hispanic
   d. Middle Eastern, North African, or Arab
   e. American Indian or Alaska Native
   f. Asian
   g. Native Hawaiian or Other Pacific Islander
   h. Other (please specify): _____

4. Do you identify as:
   a. Chaldean
   b. Assyrian
   c. Syriac
   d. Other (please specify): _____

5. What is your marital status?
   a. Married
   b. Separated
   c. Divorced
   d. Widowed
   e. Single
   f. Other (please specify): _____

6. Do you have any children?
   Yes No
   If Yes, how many?_____

7. Who lives in the same house or apartment with you? You may choose one or more.
   a. My spouse (husband or wife)
   b. My children (son or daughter)
   c. My siblings (brother or sister)
   d. My parents (mother or father)
   e. My grandparents
   f. My in-laws (mother-in-law or father-in-law)

g. My niece(s) or nephew(s)
h. My cousins
i. My aunt or uncle
j. My grandchildren
k. My son-in-law or daughter-in-law

8. How many people live in your house total?_____

9. What is the highest level of education you have completed?
   a. Elementary school
   b. Middle school
   c. High school
   d. Some college
   e. Associate's degree (2 year degree)
   f. Bachelor's degree (4 year degree)
   g. Master's degree
   h. Doctorate degree or other professional degree (ex: PhD, M.D., law degree)

10. What is your current profession? (What do you do for a living?)

_____

11. What do you consider your socioeconomic status to be?
   a. Working class
   b. Middle class
   c. Upper middle class
   d. Upper class
   e. Other (please specify): _____

12. What languages do you speak and how well?

Language		**Not Very Well**		**Average**		**Very Well**
1. English	Yes No	1	2	3	4	5
2. Arabic	Yes No	1	2	3	4	5
3. Chaldean (Aramaic)	Yes No	1	2	3	4	5
4. Other (please specify):		1	2	3	4	5
5. Other (please specify):		1	2	3	4	5

13. What country were you born in? _____

14. If you immigrated to the United States, what year did you immigrate? _____

15. If you immigrated to the United States, please indicate why. You may choose one or more.
    a. Economic opportunity
    b. Family members living in the U.S.
    c. Educational opportunity
    d. Job opportunity
    e. Future of my children or family
    f. Leave a dangerous environment
    g. Leave religious persecution
    h. Unsatisfied with government/political affairs
    i. Family members in my home country were leaving to the U.S.
    j. Other: _____
    _____

16. If you immigrated, did you enter the United States as a refugee or asylee? Yes No

17. Are you currently a(n):
    a. American citizen
    b. Permanent resident(Green Card)
    c. Visitor(Visa)
    d. Refugee or Asylee (White Card)
    e. Dual citizen (Please specify country): _____
    f. Other (Please explain):_____

18. What is your generational status?
    a. First Generation (you were born in a country other than the U.S.)
    b. Second Generation (you were born in the U.S., your parents were born in a different country)
    c. Third Generation (both you and your parents were born in the U.S., your grandparents were born in a different country)
    d. Other (please specify):_____

19. What is your religious affiliation?
    a. Chaldean Catholic
    b. Syriac Orthodox
    c. Assyrian Church of the East
    d. Christian – Protestant Denomination (ex: Baptist, Lutheran, etc.)
    Please Specify:_____
    e. Muslim (Please Specify Sect):_____
    f. Jewish
    g. Buddhist
    h. Hindu
    i. Non-religious/secular
    j. Agnostic
    k. Atheist

l. Other (please specify):_____

APPENDIX C

BACKGROUND INFORMATION IN ARABIC

استبيان معلومات الخلفية

يرجى الإجابة على هذه الاسئلة بناءً على خلفيتك الشخصية. سيتم الحفاظ على خصوصية الاجابة ولن يتم ربط الإجابات بأي اسم.

1- العمر (بالسنين): _____

2- الجنس: ذكر أنثى

3- ما هو عرقك أو أصلك؟ يمكنك إختيار واحد أو أكثر مما يلي:

أ- أبيض أو قوقازي

ب- أسود أو أفريقي أمريكي

ج- لاتيني أو إسباني

د- من الشرق الأوسط، من شمال أفريقيا أو عربي

ه- أمريكي هندي أو من سكان ألاسكا الأصليين

و- آسيوي

ز- من سكان هاواي الأصليين أو من جزر المحيط الهادي

ح- أخر (يرجى التحديد): _____

4- هل تعرف بكونك:

أ- كلداني

ب- آشوري

ج- سرياني

د- آخر (يرجى التحديد): _____

5- ما هي حالتك الإجتماعية؟

أ- متزوج

ب- منفصل

ج- مطلق

د- أرمل

ه- اعزب

و- آخر (يرجى التحديد): _____

6- هل لديك أي ابناء؟

نعم لا

إن كانت إجابتك نعم، كم العدد؟ _____

7- من يسكن معك في نفس البيت أو الشقة؟ يمكنك إختيار واحد أو أكثر من الخيارات التالية:

أ- الشريك (زوج أو زوجة)

ب- الأبناء (ولد أو بنت)

ج- اخوة (اخ أو اخت)

د- الوالدين (الوالدة أو الوالد)

ه- الأجداد

و- والدي في القانون (والدة الشريك أو والد الشريك)

ز- ابناء الأخ أو أبناء الأخت

ح- ابناء العم

ط- العمات او الأعمام

ي- الأحفاد

ك- الابناء في القانون (زوج الإبنة أو زوجة الإبن)

8- عدد الأشخاص الذين يعيشون في منزلك؟ -_____

9- ما هي أعلى درجة دراسية أكملتها؟

أ- الإبتدائية

ب- المتوسطة

ج- الإعدادية

د- القليل من الكلية

ه- درجة معهد (سنتين من الدراسة)

و- شهادة بكلوريوس (اربع سنوات من الدراسة)

ز- درجة ماجستير

ح- شهادة دكتوراه أو أي درجة تخصصية (مثل دكتوراه في الفلسفة، طب، قانون)

10- ما هو تخصصك الحالي؟ (ما الذي تقوم به للمعيشة)؟

_____

11- كيف تقدر وضعك الإجتماعي والأقتصادي؟

أ- الطبقة العاملة

ب- الطبقة المتوسطة

ج- الطبقة فوق المتوسطة

د- الطبقة العليا

ه- آخر (يرجى التحديد): _____

12- ما هي اللغات التي تعرف؟ وكيف هي اجادتك لها؟

اللغة		ليست جيدة جدا		متوسطة		جيدة جدا
1- الانكليزية	نعم لا	1	2	3	4	5
2- العربية	نعم لا	1	2	3	4	5
3- الكلدانية (الآرامية)	نعم لا	1	2	3	4	5
4- أخرى (يرجى التحديد):		1	2	3	4	5
5- أخرى (يرجى التحديد):		1	2	3	4	5

13- في أي بلد ولدت؟ _____

14- إن كنت قد هاجرت الى الولايات المتحدة، في أي سنة تمت الهجرة؟ _____

15- إن كنت قد هاجرت الى الولايات المتحدة، يرجى ذكر السبب. يمكنك اختيار واحد أو اكثر من الخيارات التالية:

أ- فرصة اقتصادية

ب- فرد من العائلة يسكن في الولايات المتحدة

ج- فرصة دراسية

د- فرصة عمل

ه- مستقبل ابنائي أو عائلتي

و- ترك محيط او مكان خطر

ز- ترك الأضطهاد الديني

ح- غير راض من الأوضاع السياسية والحكومية

ط- مغادرة بعض من الأفراد الساكنين في منزلي الى الولايات المتحدة.

ي- آخر: _____

16- في حال هجرتك، هل دخلت الولايات المتحدة كلاجئ أو لاجئ سياسي؟ نعم لا

17- هل انت حاليا:

أ- مواطن أمريكي

ب- مقيم أمريكي (حامل الكرين كارت – الكارت الأخضر)

ج- زائر (فيزا)

د- لاجئ أو لاجئ سياسي (وايت كارت – الكارت الأبيض)

ه- ثنائي الجنسية (يرجى تحديد البلد): _____

و- آخر (يرجى التحديد): _____

18- ما هو وضع جيلك؟

أ- الجيل الأول (ولدت في بلد غير الولايات المتحدة)

ب- الجيل الثاني (ولدت في الولايات المتحدة، لكن والديك من ولادة بلد اخر)

ج- الجيل الثالث (انت ووالديك من ولادة الولايات المتحدة الأمريكية، اجدادك من ولادة بلد اخر)

د- آخر (يرجى التحديد): _____

19- ما هو انتمائك الديني؟

أ- كلدان كاثوليك

ب- سريان ارثودوكس

ج- كنيسة المشرق الآشورية

د- مسيحي – المذهب البروتستانتي (مثل: المعمداني، اللوثري... الخ)

يرجى التحديد: _____

5- مسلم (يرجى تحديد المذهب): _____

6- يهودي

7- بوذي

8- هندوسي

9- غير متدين/ علماني

10- ملحد / غير متأكد من وجود الالهة

11- كافر / غير مؤمن بوجود الالهة

12- آخر (يرجى التحديد): _____

APPENDIX D

STUDY VARIABLES QUESTIONNAIRE

Helpful Terms

These are explanations of terms used throughout this survey.

Medical Health Professional: For this survey, a medical health professional is a medical doctor, such as a general physician, cardiologist, pediatrician, etc. This is a professional you would go to for a problem with your physical health, such as high blood pressure, sickness, cancer, or a broken bone.

Mental Health Professional: For this survey, a mental health professional is someone who assists with psychological or emotional problems. There are many types of mental health professionals, such as psychologists, social workers, and counselors. Mental health professionals can help with a variety of issues, such as depression, anxiety, substance use, trauma, stress, behavioral issues, and family and marital concerns. A mental health professional is typically not someone who prescribes medication to resolve issues but rather uses different forms of therapy.

Health and Human Services Questionnaire

Please answer the following questions. There are no right or wrong answers, and all of your responses will remain anonymous.

I. Current Health Status

1. Where do you usually go when you are sick or need medical care?
    a. Doctor's office or private clinic
    b. Community health center or public clinic
    c. Hospital outpatient department
    d. Hospital emergency room
    e. Urgent care or ready clinic
    f. No regular place of care
    g. Other (Please specify): _____

2. Do you have a regular doctor you usually go to when you are sick or need medical care?
    a. Yes
    b. No
    c. Other (Please specify): _____

3. Do you have a regular mental health professional (ex: psychologist, therapist, counselor, or social worker) you usually go to when in need of care?
    a. Yes
    b. No
    c. Other (Please specify): _____

4. Are you currently covered by any form of health insurance or health plan, including any private health insurance plan (ex: Blue Cross) or a government program (ex: Medicare or Medicaid)?

a. Yes, covered.
b. No, not covered.
c. Don't know.
d. Other. (Please specify): _____

5. Do you currently have any major medical concerns (ex: diabetes, heart disease, cancer)?

a. Yes
b. No
Please specify: _____

6. Do you currently have any major mental health concerns (ex: depression, anxiety, stress, trauma, substance use, marital issues)?

a. Yes
b. No
Please specify: _____

II. Identification of Available Services

Please rate the following items.

	Absolutely False	**Fairly False**	**Partially False**	**Partially True**	**Fairly True**	**Absolutely True**
1. There are enough medical doctors available to me.	1	2	3	4	5	6
2. There are enough mental health professionals (ex: psychologists, counselors) available to me.	1	2	3	4	5	6
3. I know of organizations that offer services for Chaldeans.	1	2	3	4	5	6
4. I mostly hear about different community services from Chaldean media (ex: newspaper, radio, TV)	1	2	3	4	5	6
5. There are enough services and programs available for Chaldeans.	1	2	3	4	5	6
6. I mostly hear about	1	2	3	4	5	6

different community services for Chaldeans from people I know.						

7. What services do you think need to be made available for Chaldeans? What services are missing for our community? (Ex: more services on drug abuse, violence reduction, gambling, healthy eating, etc.).

_____

_____

_____

8. What should be done to increase awareness about available services? How do we spread the word better?

_____

_____

_____

III. Utilization of Services

Please answer the following items.

1. In the past 12 months, have you visited a doctor or medical clinic for a check-up or annual exam?
   a. Yes
   b. No

2. In the past 12 months, have you visited an emergency room or urgent care to be seen by a doctor?
   a. Yes
   b. No

3. In the past 12 months, have you been admitted to the hospital?
   a. Yes
   b. No

4. In the past 12 months, have you visited a mental health professional (ex: psychologist, counselor, therapist, social worker)?

a. Yes
b. No

5. In the past 12 months, have you participated in a community program (ex: youth program, adult education, bible study, etc.)?

a. Yes
b. No
c. Please specify: _____

6. In the past 12 months, have you sought help from a religious leader (ex: priest, deacon, nun) about a personal matter?

a. Yes
b. No

7. Are there any other services or health professionals that you go to regularly?

_____

_____

_____

8. If you immigrated to the U.S., are there any differences between your experiences with services in the U.S. compared to other countries?

_____

_____

_____

IV. Responsiveness

Please rate the following items about your opinions of medical professionals (ex: doctors, dentists) and mental health professionals (ex: psychologists, therapists).

Medical Provider:	**Absolutely False**	**Fairly False**	**Partially False**	**Partially True**	**Fairly True**	**Absolutely True**	**Not Applicable**
1. It's important to me to have a medical provider that understands	1	2	3	4	5	6	

my culture.							
2. It's important to me to have a <u>medical</u> provider that speaks my native language. (If your native language is English, mark N/A).	1	2	3	4	5	6	N/A
3. It's important to me to have a <u>medical</u> provider that is of the same culture as me.	1	2	3	4	5	6	

Mental Health Provider:	**Absolutely False**	**Fairly False**	**Partially False**	**Partially True**	**Fairly True**	**Absolutely True**	**Not Applicable**
4. It's important to me to have a <u>mental health</u> provider that understands my culture.	1	2	3	4	5	6	
5. It's important to me to have a <u>mental health</u> provider that speaks my native language. (If your native language is English, mark N/A).	1	2	3	4	5	6	N/A
6. It's important to	1	2	3	4	5	6	

me to have a mental health provider that is of the same culture as me.							

7. Are there aspects of Chaldean culture that should be incorporated in services or programs?

_____

_____

_____

V. Benefits

Please rate the following items on how much they impact your decision to use medical and mental health services.

Medical Care:	**Absolutely False**	**Fairly False**	**Partially False**	**Partially True**	**Fairly True**	**Absolutely True**
1. When I seek help from a medical professional, I am doing something to take care of myself.	1	2	3	4	5	6
2. I have a lot to gain by seeking medical care.	1	2	3	4	5	6

Mental Health Care:	**Absolutely False**	**Fairly False**	**Partially False**	**Partially True**	**Fairly True**	**Absolutely True**
3. When I seek help from a mental health professional, I am doing something to take care of myself.	1	2	3	4	5	6
4. I have a lot to gain by seeking mental health care.	1	2	3	4	5	6

5. What motivates you to seek medical care or mental health care?

_____

_____

_____

6. Is there anything that would make it easier for you to seek care?

_____

_____

_____

VI. Barriers to Service Utilization

Please rate the following items on how much they impact your decision to use medical and mental health services.

Medical Care:	**Absolutely False**	**Fairly False**	**Partially False**	**Partially True**	**Fairly True**	**Absolutely True**
1. Seeking medical care takes too much time.	1	2	3	4	5	6
2. I have other problems more important to take care of than my physical health.	1	2	3	4	5	6
3. It is not necessary to seek professional medical care for physical health concerns.	1	2	3	4	5	6
4. It is embarrassing to seek care for certain physical health concerns.	1	2	3	4	5	6

Mental Health Care:	**Absolutely False**	**Fairly False**	**Partially False**	**Partially True**	**Fairly True**	**Absolutely True**
5. Seeking mental health care takes too much time.	1	2	3	4	5	6
6. I have other problems more important to take care of than my mental health.	1	2	3	4	5	6
7. It is not necessary to seek professional mental health care for personal concerns.	1	2	3	4	5	6
8. It is embarrassing to seek care for certain mental health concerns.	1	2	3	4	5	6

9. What keeps you from seeking medical care or mental health care?

_____

_____

_____

10. Is there anything that makes it physically difficult for you to seek care (ex: transportation, language, distance, money, etc.)?

_____

_____

_____

VII. Other Factors in Service Utilization

Please rate the following items on how much they impact your decision to use a service.

	Absolutely False	**Fairly False**	**Partially False**	**Partially True**	**Fairly True**	**Absolutely True**
1. I feel confident about how to seek medical care from a professional.	1	2	3	4	5	6
2. I feel confident about how to seek mental health care from a professional.	1	2	3	4	5	6
3. I don't like going to the doctor because I fear hearing bad news.	1	2	3	4	5	6
4. I don't get help right away because I think the issue will go away on its own.	1	2	3	4	5	6
5. Sometimes I want to get care for issues that I don't want anyone to find out about.	1	2	3	4	5	6
6. Some services are just too expensive for me to go to.	1	2	3	4	5	6

7. I don't know what services are out there for me.	1	2	3	4	5	6
8. Chaldean organizations do a good job of providing helpful services.	1	2	3	4	5	6

10. Please rate how likely you would be to seek help from the following people for a personal or mental health concern.

	Never	Rarely	Sometimes	Occasionally	Usually	Always
1. Friend	1	2	3	4	5	6
2. Psychologist	1	2	3	4	5	6
3. Teacher	1	2	3	4	5	6
4. Social Worker	1	2	3	4	5	6
5. Priest	1	2	3	4	5	6
6. Counselor	1	2	3	4	5	6
7. Family Member	1	2	3	4	5	6

Is there anything else not included on this survey that you would like to share?

_____

_____

_____

APPENDIX E

STUDY VARIABLES QUESTIONNAIRE IN ARABIC

مصطلحات مفيدة

ما يلي شرح للمصطلحات المستخدمة في هذا الاستطلاع:

اخصائي الطب والصحة البدنية: في الاستطلاع، المقصود بهذا المصطلح هو الطبيب، كاخصائي عام، اخصائي قلب، اخصائي أطفال... الخ. والمقصود به أي اخصائي طبي تقوم بزيارته في حال حدوث اي مشاكل صحية، كإرتفاع ضغط الدم، المرض، السرطان، او كسر العظام.

أخصائي الصحة الذهنية: في الاستطلاع، المقصود بهذا المصطلح هو الشخص الذي يقوم بمساعدتك في المشاكل النفسية والعاطفية. هناك عدة انواع من اخصائيي الصحة الذهنية، كعلماء النفس، الأخصائيين الإجتماعيين، والمستشارين. يقوم اخصائيو الصحة الذهنية بالمساعدة في مختلف المشاكل، كالاكتئاب، القلق، تعاطي المخدرات، الصدمات، الضغط النفسي، مخاوف في القضايا السلوكية والعائلية والمشاكل الزوجية. لا يقوم اخصائي الصحة الذهنية بوصف أي أدوية في العادة لكنه يقوم بحل المشاكل بطرق علاجية مختلفة.

استطلاع الصحة والخدمات الإنسانية

يرجى الإجابة على الأسئلة التالية. لا توجد اجابة صحيحة أو خاطئة لهذه الأسئلة، بالإضافة الى أن جميع اجوبتك ستبقى مجهولة المصدر.

أ- الوضع الصحي الحالي

1- اين تذهب عادة في حال مرضك أو عند حاجتك للرعاية الطبية؟
   أ- عيادة الطبيب أو عيادة خاصة
   ب- مركز صحة المجتمع أو عيادة عامة
   ج- قسم العيادات الخارجية في المستشفى
   د- غرفة الطوارئ في المستشفى
   ه- الرعاية العاجلة أو العيادات الجاهزة للطوارئ
   و- لا يوجد مكان محدد للرعاية
   ز- آخر (يرجى التحديد): _____

2- هل لديك طبيب محدد تذهب اليه عند مرضك أو عند حاجتك للرعاية الطبية؟
   أ- نعم

ب- لا
ج- آخر (يرجى التحديد): _____

3- هل لديك اخصائي صحة ذهنية تذهب اليه عند الحاجة للرعاية (كطبيب نفسي، معالج، استشاري او عامل اجتماعي)؟
أ- نعم
ب- لا
ج- آخر (يرجى التحديد): _____

4- هل لديك تغطية من التأمين الصحي أو خطط صحية، من ضمنها أي خطة تأمين صحي خاصة (مثل الصليب الازرق – بلو كروس) أو أي برنامج حكومي (مثل: ميديكير أو ميديكيد)؟
أ- نعم لدي تغطية
ب- لا، ليس لدي تغطية
ج- لا أعلم
د- آخر (يرجى التحديد): _____

5- هل لديك حاليا أي مخاوف من مشاكل صحية كبيرة (كالسكري، امراض القلب، سرطان)؟
أ- نعم
ب- لا
يرجى التحديد: _____

6- هل لديك حاليا أي مخاوف من مشاكل ذهنية خطيرة (كالاكتئاب، القلق، تعاطي المخدرات، الصدمات، الضغط النفسي، مخاوف في القضايا السلوكية والعائلية والمشاكل الزوجية)؟
أ- نعم
ب- لا
يرجى التحديد: _____

ب- تحديد الخدمات المتوفرة

يرجى تقييم الفقرات التالية.

	خاطئة تماما	خاطئة بانصاف	خاطئة نوعا ما	صحيحة نوعا ما	صحيحة بانصاف	صحيحة تماما
1- هناك ما يكفي من الأطباء متوفرين لي	1	2	3	4	5	6
2- هناك ما يكفي من اخصائيي علم النفس متوفرين لي (كطبيب نفسي، استشاري).	1	2	3	4	5	6

3- لدي العلم بمنظمات تقدم الخدمات للكلدان	1	2	3	4	5	6
4- في الغالب اعلم بخصوص مختلف الخدمات الاجتماعية عن طريق وسائل الاعلام الكلدانية (كالصحف، الراديو، التلفاز)	1	2	3	4	5	6
5- هناك ما يكفي من الخدمات والبرامج المتوفرة للكلدان.	1	2	3	4	5	6
6- في الغالب اعلم بخصوص مختلف الخدمات الاجتماعية عن طريق أناس اعرفهم.	1	2	3	4	5	6

7- ما هي الخدمات التي تعتقد بضرورة توفيرها للكلدان؟ ما هي الخدمات المفتقدة في مجتمعنا؟ (كمثال: المزيد من الخدمات فيما يخص تعاطي المخدرات، الحد من العنف، القمار، تناول الطعام الصحي... الخ).

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8- ما الذي يجب عمله لزيادة الوعي بخصوص توفر الخدمات؟ كيف يمكن نشر المعلومات بشكل أكبر؟

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ج- الاستفادة من الخدمات

يرجى الاجابة على الفقرات التالية:

1- خلال 12 شهرا الماضية، هل قمن بزيارة طبيب او عيادة طبية للمراجعة او القيام بالفحص السنوي؟

أ- نعم

ب- لا

2- خلال 12 شهرا الماضية، هل قمت بزيارة غرفة الطوارئ او الرعاية الطارئة ليتم فحصك من قبل طبيب؟

أ- نعم

ب- لا

3- خلال 12 شهرا الماضية، هل تم ادخالك الى المستشفى؟
أ- نعم
ب- لا

4- خلال 12 شهرا الماضية، هل قمت بزيارة اخصائي صحة ذهنية (كطبيب نفسي، استشاري، معالج، عامل اجتماعي)؟
أ- نعم
ب- لا

5- خلال 12 شهرا الماضية، هل قمت بالمشاركة في برنامج اجتماعي (مثل: برنامج شبابي، تعليم البالغين، دراسة الكتاب المقدس... الخ)؟
أ- نعم
ب- لا
ج- يرجى التحديد: _____

6- خلال 12 شهرا الماضية، هل قمت بطلب المساعدة من مسؤول ديني (مثل: كاهن، شماس، راهبة) بخصوص موضوع شخصي؟
أ- نعم
ب- لا

7- هل هناك أي خدمات او اخصائيي صحة محددين تقوم بزيارتهم بانتظام؟

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8- في حال هجرتك الى الولايات المتحدة، هل يوجد اي فروقات بين تجاربك فيما يخص الخدمات في الولايات المتحدة بالمقارنة مع البلدان الأخرى؟

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د- الادراك

يرجى تقييم الفقرات التالية فيما يخص رأيك عن الاخصائيين الطبيين (كالاطباء، اطباء الأسنان) واخصائيي الصحة الذهنية (كالاطباء النفسيين، معالجين نفسيين).

المعالج الطبي	خاطئة تماما	خاطئة بانصاف	خاطئة نوعا ما	صحيحة نوعا ما	صحيحة بانصاف	صحيحة تماما	لا ينطبق
1- يهمني أن يكون لي مقدم رعاية صحية يفهم عرقي.	1	2	3	4	5	6	
2- يهمني ان يكون لي مقدم رعاية صحية يتكلم لغتي (قم باختيار "لا ينطبق" ان كانت لغتك الأصلية هي الانكليزية)	1	2	3	4	5	6	لا ينطبق
3- يهمني أن يكون لي مقدم رعاية صحية من نفس عرقي.	1	2	3	4	5	6	
مقدم الرعاية الذهنية:	خاطئة تماما	خاطئة بانصاف	خاطئة نوعا ما	صحيحة نوعا ما	صحيحة بانصاف	صحيحة تماما	لا ينطبق
4- يهمني أن يكون لي مقدم رعاية ذهنية يفهم عرقي.	1	2	3	4	5	6	
5- يهمني ان يكون لي مقدم رعاية ذهنية يتكلم لغتي (قم باختيار "لا ينطبق" ان كانت لغتك الأصلية هي الانكليزية)	1	2	3	4	5	6	لا ينطبق
6- يهمني أن يكون لي مقدم رعاية ذهنية من نفس عرقي.	1	2	3	4	5	6	

7- هل هناك جوانب من الثقافة الكلدانية التي ينبغي ادراجها في الخدمات أو البرامج؟

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هـ- الفوائد

يرجى تقييم الفقرات التالية عن العوامل المؤثرة على قراراتك بخصوص استخدام الخدمات الصحية والذهنية المقدمة.

الخدمات الصحية الجسدية	خاطئة تماما	خاطئة بانصاف	خاطئة نوعا ما	صحيحة نوعا ما	صحيحة بانصاف	صحيحة تماما
1- اني اقوم بشي للاهتمام بنفسي حين اطلب المساعدة من اخصائي طبي.	1	2	3	4	5	6
2- لدي الكثير لاكسبه عند طلب الرعاية الطبية الجسدية.	1	2	3	4	5	6

الخدمات الذهنية	خاطئة تماما	خاطئة بانصاف	خاطئة نوعا ما	صحيحة نوعا ما	صحيحة بانصاف	صحيحة تماما
3- اني اقوم بشي للاهتمام بنفسي حين اطلب المساعدة من اخصائي صحي ذهني.	1	2	3	4	5	6
4- لدي الكثير لاكسبه عند طلب الرعاية الصحية الذهنية.	1	2	3	4	5	6

5- ما الذي يدفعك للبحث وطلب الرعاية الصحية أو الرعاية الذهنية؟

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6- هل هناك اي شئ يمكن أن يسهل عليك عملية طلب المساعدة الطبية؟

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Barriers .VI

يرجى تقييم الفقرات التالية عن العوامل المؤثرة على قراراتك بخصوص استخدام الخدمات الصحية والذهنية المقدمة.

الخدمات الصحية الجسدية	خاطئة تماما	خاطئة بانصاف	خاطئة نوعا ما	صحيحة نوعا ما	صحيحة بانصاف	صحيحة تماما
1- طلب المساعدة الطبية يستغرق وقتا طويلاً.	1	2	3	4	5	6
2- لدي مشاكل اهم من الاهتمام بصحتي البدنية.	1	2	3	4	5	6
3- من لا الضروري طلب المساعدة الطبية في حال وجود مخاوف من مشاكل صحة بدنية	1	2	3	4	5	6
4- من المخجل البحث عن المساعدة الطبية فيما يخص بعض المشاكل الصحية البدنية.	1	2	3	4	5	6

الخدمات الصحية الذهنية	خاطئة تماما	خاطئة بانصاف	خاطئة نوعا ما	صحيحة نوعا ما	صحيحة بانصاف	صحيحة تماما
5- طلب المساعدة الذهنية يستغرق وقتا طويلاً.	1	2	3	4	5	6
6- لدي مشاكل اهم من الاهتمام بصحتي الذهنية	1	2	3	4	5	6
7- من لا الضروري طلب المساعدة الطبية في حال وجود	1	2	3	4	5	6

مخاوف من مشاكل صحة ذهنية						
8- من المخجل البحث عن المساعدة الطبية فيما يخص بعض المشاكل الصحية الذهنية.	1	2	3	4	5	6

9- ما الذي يمنعك من البحث عن المساعدة الطبية البدنية أو الذهنية؟

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10- هل هناك أي معوقات تصعب عليك طلب المساعدة الطبية (كالنقل، اللغة، بعد المسافة، المال... الخ)؟

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ز- العوامل الأخرى المؤثرة على الانتفاع من الخدمات

يرجى تقييم الفقرات التالية عن العوامل المؤثرة على قراراتك بخصوص استخدام الخدمات المقدمة.

	خاطئة تماما	**خاطئة بانصاف**	**خاطئة نوعا ما**	**صحيحة نوعا ما**	**صحيحة بانصاف**	**صحيحة تماما**
1- اشعر بالثقة بخصوص اسلوب طلب المساعدة الطبية البدنية من اخصائي.	1	2	3	4	5	6
2- اشعر بالثقة بخصوص اسلوب طلب المساعدة الطبية الذهنية من اخصائي.	1	2	3	4	5	6
3- لا يعجبني الذهاب الى الطبيب لأنني اخاف من سماع أخبار سيئة.	1	2	3	4	5	6

4- لا أطلب المساعدة فوراً لاعتقادي بأن المشكلة ستحل نفسها مع الوقت.	1	2	3	4	5	6
5- في بعض الأحيان أرغب بالحصول على المساعدة في قضايا خاصة لا اريد لأحد أن يعلم بها.	1	2	3	4	5	6
6- بعض الخدمات مكلفة جدا بالنسبة لي لأطلبها.	1	2	3	4	5	6
7- لا أعلم ما هي الخدمات المتوفرة لي في المجتمع.	1	2	3	4	5	6
8- تقوم المنظمات الكلدانية باعمل جيد في تقديم الخدمات والمساعدات.	1	2	3	4	5	6

10- يرجى تقييم مقدار رغبتك بالحصول على المساعدة من الاشخاص التاليين فيما يخص مخاوفك من الحالات الخاصة البدنية أو الذهنية

	أبداً	**نادراً**	**في بعض الحالات**	**احيانا**	**غالباً**	**دائماً**
1- صديق	1	2	3	4	5	6
2- طبيب نفسي	1	2	3	4	5	6
3- معلم	1	2	3	4	5	6
4- عامل اجتماعي	1	2	3	4	5	6
5- كاهن	1	2	3	4	5	6
6- استشاري	1	2	3	4	5	6
7- فرد من العائلة	1	2	3	4	5	6

هل هناك شئ آخر غير مذكور في هذا الاستطلاع ترغب بمشاركاته معنا؟

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APPENDIX F

SURVEY COVER LETTER IN ENGLISH AND ARABIC

Hello,

My name is Veronica Kassab, and I am working to complete my PhD at Central Michigan University. As a member of the Chaldean community and having worked for Chaldean organizations in the past, I am committed to seeing all Chaldeans thrive in America. This survey will not only help me complete my degree but will also provide much needed information about Chaldeans. The questions on the survey will ask you about your background, your experiences using physical and mental health care services, attitudes about your ethnic identity, and your suggestions for future services for Chaldeans. Your responses will be anonymous and no one will know who you are. Volunteering to take this survey will provide valuable information that will make services for Chaldeans better and help us understand what needs to be done for our community. Thank you in advance for your time and consideration! This would not be possible without your support!

Appreciatively,
Veronica A. Kassab, MA
Clinical Psychology Doctoral Candidate
Central Michigan University

مرحبا:
اسمي فيرونكا كساب، أنا اعمل على اكمال شهادة الدكتوراه في جامعة سنترال مشيكان (Central Michigan University). أنا ملزمة كعضوة في المجتمع الكلداني وكوني عملت في المنظمات الكلدانية في الماضي على رؤية ازدهار الكلدان في أمريكا. سيساعد هذا الاستطلاع لا فقط على اكمال دراستي لكن ايضا على توفير معلومات أكثر عن الكلدان. الاسئلة في هذا الاستطلاع ستكون عن خلفيتك، خبرتك وتجاربك في استخدام خدمات الرعاية الصحة البدنية والذهنية، السلوك بخصوص هويتك العرقية، واقتراحاتك بخصوص الخدمات المستقبلية للكلدان. اجاباتك ستكون مجهولة الهوية ولن يعلم أحد من تكون. التطوع لإكمال هذا الاستطلاع سيزودنا بمعلومات قيمة لتطوير الخدمات للكلدان بشكل أفضل ويساعدنا على فهم ما يمكن فعله لمجتمعنا. أشكركم مقدما على وقتكم الثمين وعلى اهتمامكم! لن يمكن إكمال هذا العمل بدون مساعدتكم ودعمكم!
مع فائق التقدير
فيرونكا أ. كساب، حاصلة على شهادة ماجستير (MA)
طالبة الدكتوراه في علم النفس العيادي
جامعة سنترال مشيكان

APPENDIX G

RAFFLE ENTRY FORM IN ENGLISH AND ARABIC

Thank you for participating in this study!

If you would like to enter to win a $25 Target gift card, please provide your first name (ONLY) and an email address or mailing address to where it can be sent.

You do NOT need to provide your last name, and this information will never be associated with your responses.

First Name (ONLY): _____

Email Address: _____

OR

Mailing Address: _____

شكرا لمشاركتك في هذا الاستطلاع!

اذا كنت ترغب بالدخول في سحبة للفوز بكارت تاركت بقيمة 25$، يرجى تزويدنا **بأسمك الأول (فقط)**

وبريدك الألكتروني أو عنوان بريدك المحلي حيث يمكننا ارسال الكارت لك في حال فوزك.

لا داعي لتزويدنا باسمك الكامل، هذه المعلومات لن يتم ذكرها او ربطها باجاباتك في الاستطلاع.

اسمك الأول **(فقط)**: _____

عنوان بريدك الألكتروني: _____

أو

عنوان بريدك: _____

REFERENCES

Abdulrahim, S., & Baker, W. (2009). Differences in self-rated health by immigration status and language preference among Arab Americans in the Detroit metropolitan area. *Social Science and Medicine*, 68, 2097-2103. doi:10.1016/j.socscimed.20 09.04.017

Acevedo-Polakovich, I. D., Crider, E., Kassab, V. A., & Gerhart, J. I. (2011). Increasing service parity through organizational cultural competence. In L. P. Buki & L. M. Piedra (Eds.), Creating infrastructures for Latino mental health. (pp. 79-98). New York, NY: Springer.

Al-Rasheed, M. (1994). The myth of return: Iraqi Arab and Assyrian refugees in London. *Journal of Refugee Studies*, 7, 199-219.

Arkfen, C. L., Kubkiak, S. P., & Farrag, M. (2008). Arab Americans in publicly financed alcohol/other drug abuse treatment. *Alcoholism Treatment Quarterly*, 26(3), 229-240. doi: 10.1080/07347320802071547

Becker, M. H. (Ed.). (1974). *The Health Belief Model and personal health behavior*. Thorofare, NJ: Charles B. Slack.

Dallo, F. J., Zakar, T., Borrell, L. N., Fakhouri, M., & Jamil, H. (2011). Cancer knowledge increased after a brief intervention among Arab Americans in Michigan. *Journal of Cancer Education*, 26, 139-146. doi: 10.1007/s13187-010-0179-6

El-Sayed, A.M., & Galea, S. (2009). The health of Arab-Americans living in the United States: a systematic review of the literature. *BMC Public Health, 9, 272-281.* Doi:10.1186/1471-2458-9-272

Ezzati-Rice, T., & Rohde, F. (2008). Statistical brief 201: Variation in ambulatory health care visits and visits for general checkup by demographic characteristics and insurance status, U.S. civilian noninstitutionalized population Ages 18–64, 2005. U.S. Department of Health and Human Services. Retrieved from: http://meps.ahrq.gov/mepsweb/data_files/publications/st201/stat201.shtml

Hajjar, S. (2008). Iraq's persecution of Christians continues to spiral out of control. *Chaldean.org*. Retrieved from: http://www.chaldean.org/Home/tabid/36/articleType/ArticleView/articleId/308/Iraqs-Persecution-of-Christians-Continues-to-Spiral-out-of-Control.aspx

Hakim-Larson, J., Kamoo, R., Nassar-McMillan, S. C., & Porcerelli, J. H. (2007). Counseling Arab and Chaldean American families. *Journal of Mental Health Counseling*, 29, 301-321.

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, 23*, 56-62. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC495331/pdf/jnnpsyc00273-0060.pdf

Jamil, H., Dallo, F., Fakhouri, M., Templin, T., Khoury, R., & Fakhouri, H. (2009). The prevalence of self-reported chronic conditions among Arab, Chaldean, and African Americans in southeast Michigan. *Ethnicity and Disease,* 19, 293-300.

Jamil, H., Fakhouri, M., Dallo, F., Templin, T., Khoury, R., & Fakhouri, H. (2008a). Disparities in self-reported diabetes mellitus among Arab, Chaldean, and Black Americans in southeast Michigan. *Journal of Immigrant Minority Health*, 10, 397-405. doi: 10.1007/s10903-007-9108-0

Jamil, H., Grzybowski, M., Hakim-Larson, J., Fakhouri, M., Sahutoglu, J., Khoury, R., & Fakhouri, H. (2008b). Factors associated with self-reported depression in Arab, Chaldean, and African Americans. *Ethnicity and Disease*, 18, 464-470.

Jamil, H., Nassar-McMillan, S. C., & Lambert, R. G. (2007). Immigration and Attendant Psychological Sequalae: A Comparison of Three Waves of Iraqi Immigrants. *Journal of Orthopsychiatry*. 77(2), 199-205.

Jamil, H., Nassar-McMillan, S., Lambert, R., Wang, Y., Ager, J., & Arntez, B. (2010). Pre- and post-displacement stressors and time of migration as related to self-rated health among Iraqi immigrants and refugees in Southeast Michigan. *Medicine, Conflict, and Survival*, 26, 207-222. doi: 10.1080/13623699.2010.513655

Jamil, H., Raymond, D., Fakhouri, M., Templin, T., Khoury, R., Fakhouri, H., & Arnetz. (2011). Self-reported asthma in Chaldeans, Arabs, and African Americans: Factors associated with Asthma. *Journal of Immigrant and Minority Health*, 13, 568-575. doi: 10.007/s10903-010-9390-0

Jamil, H., Templin, T., Fakhouri, M., Rice, V.H., Khouri, R., Fakhouri, H., Al-Omran, H., Al-Fauori, I., & Baker, O. (2008c). Comparison of Personal Characteristics, Tobacco Use, and Health States in Chaldean, Arab American, and non-Middle Eastern White Adults. *Journal of Immigrant and Minority Health*. doi: 10.1007/s10903-008-9125-7

Kashihara, D., & Carper, K. (2009). Statistical brief 272: National health care expenses in the U.S. civilian noninstitutionalized population, 2007. U.S. Department of Health and Human Services. Retrieved from: http://meps.ahrq.gov/mepsweb/data_files/publications/st272/stat272.shtml

Kridli, S. A. (2002). Health beliefs and practices among Arab women. *American Journal of Maternal Child Nursing*, 27, 178-182.

Kridli, S. A., Herman, W. H., Brown, M. B., Fakhouri, H., & Jaber, L. A. (2005). The epidemiology of diabetes and its risk factors among Chaldean Americans. *Ethnicity and Disease*, 15, 30-31.

Kridli, S. A., Herman, W. H., Brown, M. B., Fakhouri, H., & Jaber, L. A. (2006). The epidemiology of diabetes and its risk factors among Chaldean Americans. *Ethnicity and Disease*, 16(2), 351-356.

Kumar, R., Seay, N., & Karabenick, S. (2011). Shades of white: Identity status, stereotypes, prejudice, and xenophobia. *Educational Studies*, 47, 347-378. doi: 10.1080/00131946.2011.587922

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. Behaviour Research and Therapy, 33, 335-342.

Maramba, G. G., & Nagayama Hall, G. C. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity and Ethnic Minority Psychology*, 8(3), 290-297. doi: 10.1037/1099-9809.8.3.290

Perkins, D. F., Borden, L. M., Villarruel, F. A., Carlton-Hug, A., Stone, M. R., & Keith, J. G. (2007). Participation in structured youth programs: Why ethnic minority urban youth choose to participate – or not to participate. *Youth and Society*, 38, 420-442. doi: 10.1177/0044118X06295051

Rice, V. H., Weglicki, L. S., Templin, T., Hammad, A., Jamil, H., & Kulwicki, A. (2006). Predictors of Arab American Adolescent Tobacco Use. *Merrill-Palmer Quarterly*, 52(2), 327-342.

Riggs, E., Davis, E., Gibbs, L., Block, K., Szwarc, J., Casey, S., Duell-Piening, P., & Waters, E. (2012). Accessing maternal and child health services in Melbourne, Australia: Reflections from refugee families and service providers. *BMC Health Services Research*, 12, 117-133. doi: 10.1186/1472-6963-12-117

Rubin, L., & Bhavnagri, N.P. (2001). Voices of recent Chaldean Adolescent Immigrants. *Childhood Education*, 308-312.

Schwartz, K. L., Fakhouri, M., Bartoces, M., Monsur, J., & Younis, A. (2008). Mammography screening among Arab American women in metropolitan Detroit. *Journal of Immigrant Minority Health*, 10, 541-549. doi: 10.1007/s10903-008-9140-8

Sengstock, M. C. (2010). *Chaldean Americans*. Retrieved from: http://www.everyculture.com/multi/Bu-Dr/Chaldean-Americans.html

Shoeb, M., Weinstein, H., & Halpern, J. (2007). Living in Religious Time and Space: Iraqi Refugees in Dearborn, Michigan. *Journal of Refugee Studies*, 20(3), 441-460.

Sterling, J. (2008). Iraq Christians face 'bleak future'. *Cable News Network (CNN)*. Retrieved from: http://www.cnn.com/2008/WORLD/meast/12/24/iraq.christians/index.html?iref=allsearch

Sue, S, Fujino, D. C., Hu, L., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, 59(4), 533-540. doi: 10.1037/0022-006X.59.4.533

U.S. Census Bureau. (2003). Census 2000 brief: The Arab population: 2000. Retrieved from: https://www.census.gov/prod/2003pubs/c2kbr-23.pdf

U.S. Census Bureau. (2011). Table 52: Population by selected ancestry group and region: 2008. Retrieved from http://www.census.gov/compendia/statab/2011/tables/11s0052.pdf

U.S. Department of State. (2008). International religious freedom report: 2008. Retrieved from: http://www.state.gov/j/drl/rls/irf/2008/108483.htm

Zane, N., Sue, S., Chang, J., Huang, L., Huang, J., Lowe, S., . . . Lee, E. (2005). Beyond ethnic match: Effects of client-therapist cognitive match in problem perception, coping orientation, and therapy goals on treatment outcomes. *Journal of Community Psychology*, *33*, 569-585. doi: 10.1002/jcop.200