Religious Coping, Symptoms of Depression and Anxiety, and Well-being among Somali College Students

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Introduction

A major consequence of the protracted, 23-year conflict in Somalia has been a large number of refugees resettling in many countries worldwide. In the U.S., Minnesota hosts the largest Somali population of any state. With a median age of 25 years, Somalis are 12 years younger than the general population in Minnesota. Refugee parents who experienced various types of trauma and loss may have developed maladaptive coping mechanisms which they may have transferred to their children. Consequently, mental health problems may emerge during immigrant children’s early developmental years and persisted into their early adulthood. Published reports have revealed moderate to high rates of anxiety, depression, chemical use and trauma among young adult Somalis. Academic settings are ideal for promotion of physical and emotional well-being, and prevention and detection of mental health disorders. Empirical observations have revealed that during crises people tend to turn to matters of faith for coping. In addition, religious coping is a strong predictor of health outcomes, but there are few studies that were conducted with young, non-western, non-Christian samples.

Purpose

The purpose of this study was to examine the associations among positive and negative religious coping, physical and emotional well-being, symptoms of anxiety, and symptoms of depression among university students of Somali origin in the Twin Cities, Minneapolis.

Methodology

The study design was a cross-sectional, web-based survey. The survey was hosted on the University of Minnesota REDCap database. Study criteria included: English speaking Somali students aged between 18–30, and enrolled in 5 universities in the Twin Cities. Measures included in the survey to describe the sample were: demographic questions, the Benet-Martinez Acculturation Scale, the Social Readjustment Scale. Measures included in the survey to measure the six key variables were: the Hopkins Symptom checklist (depression and anxiety subscales), SF12v2® (physical and emotional well-being) and the Brief RCOPE (positive and negative religious coping). The survey was piloted with 6 Somali students and their feedback was discussed with a community advisory board prior to finalizing the survey. Data collection lasted for 6 months.

Results

There were 193 Somali students who expressed interest in participating in the study and received a link to the survey; 166 students who opened the survey link; and 156 who provided sufficient data to be included in the data analyses. The average age of the students was 21 years and most were single (n = 147) and worked part-time (n = 100). See Figure 1 for their respective countries of birth.
Health outcomes: Participants reported experiencing slightly more symptoms of depression ($M = 1.53$, $SD = .57$, range 1 to 3.4) than symptoms of anxiety ($M = 1.46$, $SD = .46$, range 1 to 3.3) with 1 representing no symptoms of depression or anxiety and 4 representing an extremely high level of anxiety and depression symptoms. Participants had higher levels of physical well-being ($M = 53.6$, $SD = 6.4$, range 26.11 to 66.55) than emotional well-being ($M = 49.4$, $SD = 9.3$, range 10.07 to 64.52) on a scale that was normed by the developers to have a mean of 50 and standard deviation of 10. Seventeen percent of the participants were at risk of being diagnosed with depression.

Religious coping: Participants overwhelmingly endorsed positive religious coping mechanisms. Scores on the positive religious coping scale were high on average ($M = 3.36$, $SD = .68$, range 1.14 to 4) whereas negative religious coping scale scores were much lower on average ($M = 1.36$, $SD = .52$, range 1 to 4). For both scales, 1 represented a low score and 4 a high score. In a multivariate analysis, in which co-variances among the six key variables were controlled, significant associations were found between the following pairs of variables: positive religious coping was positively associated with emotional well-being ($b = 1.39; p < .001$) and negatively with physical well-being ($b = -0.45; p < .04$) and depression ($b = -0.04; p = .05$). Negative religious coping was positively associated with depression ($b = 0.06; p = .01$) and anxiety ($b = 0.04; p = .02$). Given that this was a cross-sectional, exploratory study, it was not possible to determine the direction of these associations.

Dissemination: The preliminary results were presented at the Midwest Nursing Research Society (MNRS) conference in March 2014. The final results will be presented at American Public Health Association (APHA) conference in November 2014. In the next academic year 2014-2015, I plan to submit at least three manuscripts for publication to suitable, high quality, peer reviewed professional journals.
Financial Summary

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount Spent</th>
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<tbody>
<tr>
<td><strong>Stipend:</strong> Graduate assistant salary ($24.94/hr.) and fringe benefits (20 hrs. /wk., 7/1/13 – 8/31/13)</td>
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<td><strong>Equipment:</strong> Survey completion incentive (bookstore cards for Augsburg, St. Catherine, Hamline and Metropolitan State Universities and gopher gold for UMN students)</td>
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<td>SPSS software</td>
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<td><strong>Travel:</strong> Dissemination:</td>
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<td>MNRS conference (03-29-2014)</td>
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<tr>
<td>APHA conference (11-19-2014)</td>
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<td><strong>Total:</strong></td>
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Note.
a Some participants declined the $20 compensation, thus the amount distributed was less than what was initially budgeted for in the award.

In the table above, the expended funds and a forecast of expenses for the Fall 2014 APHA conference in New Orleans are reflected.

Future Project Plans

From the results obtained, it is evident that religious coping holds central importance for many young Somalis during critical life events and it has strong associations with both physical and emotional well-being. Positive religious coping was also associated with a decrease in symptoms of depression. These results will serve as a foundation for future post-doctoral research work in developing and testing integrated care models that are supportive and respectful of the religious beliefs and spirituality of refugee and immigrant youth and young adults. Such care models could be especially helpful for prevention and treatment of depression and anxiety, drug and alcohol abuse and interpersonal violence. I also plan to extend the study to other groups of young adults (e.g., Sudanese, Ethiopian and Kenyan). Integrative care for persons who use religious coping in their journey to recovery is not only cost effective but also takes into account a culturally acceptable and, therefore, sustainable mechanism of coping.

This study was part of my PhD dissertation and the oral PhD defense is scheduled for August 20, 2014.