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African Immigrants' U.S. Experience of Mental Health, Mental Illness, and Help-Seeking

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Abstract

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By

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MS, Walden University, 2012

BS, Walden University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

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Abstract

The purpose of this study was to qualitatively examine and explore African immigrants' U.S. experience of mental health, mental illness, and help-seeking. Mental health, mental illness, and help-seeking are misunderstood public health issues. Indigenous cultural stigma concerning mental illness and help-seeking and mistrust of Western medicine inhibit African immigrants from reporting mental illness and seeking treatment. The segmented assimilation theory (SAT) and cultural risk theory (CRT) and interpretive phenomenological analysis (IPA) were used to guide data collection and analysis. Data were collected from a sample of 9 African immigrants who migrated from countries within the Five Main Regions of Africa to the U.S. using a semi-structured interview guide. The six-step data analysis method was used in this study as a guide to the thematic analysis. The themes associated with each research question were as follows: assumptions and expectations and experience of mental health, cultural experience of mental illness and participant occupation, meanings of help-seeking and subject of story, and importance of cultural understanding and dissatisfaction. The results of this study show how different traditional cultural beliefs are experienced in a foreign country and how culturally distinct immigrants struggled with risks and problems. The results of this research point to rigorous and meaningful recommendations for policy and practice, leading to positive social change including recruitment and training of psychologists who understand African immigrants and come from the same cultural background.

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Dedication

I dedicate this study to my late father, Chief (Pastor) Joseph Offiong Edem, who was my best friend, counselor, and teacher who taught me the significance of education for continued development and progress. I dedicated this study to my late mother, Deaconess Affiong Edem, who never got a chance to be formally educated yet instilled the value of education in all her seven children. I dedicate this study to my late aunt, Deaconess Aggie Sampson, who like my mother never got a chance to be formally educated but instilled the value of higher in education in me. I dedicate this study to my late senior brother, Mr. Ime Joseph Offiong Edem and late sister, Miss Grace Joseph 0ffiong Edem who believed before I did, that I should be given a chance for higher education beyond Primary School and above. I dedicate this study to my eldest brother, His Elate Excellency, Ambassador Samuel Joseph Offiong Edem, the first university graduate in the Edem Family who encouraged and believed before I did, that I could complete this Ph.D. Finally, I dedicate this study to all the members of the Edem Family for them to know that age is not a barrier to education, negativity has no room in success, positive thinking enhances hope and that the sky is the only limit to academic and professional accomplishments.

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Chapter 1: Introduction to the Study

This qualitative study explored African immigrants' experiences in the United States (U.S.) involving mental health, mental illness, and help-seeking. The rationale for this study was to explore the unique experiences of this immigrant group, as their numbers in the U.S. constitute a substantive minority who need mental health services that could address mental health issues as well as challenges regarding cultural assimilation and loss of home and identity. Furthermore, different and culturally-based social stigma involving mental health conditions and help-seeking problems inhibit minority immigrants from reporting mental illnesses and seeking treatment (Schock-Giordano, 2013). African immigrants are vulnerable to social discrimination and assumptions of criminality, which impacts their willingness to explore and use mental healthcare services (Dale & Daniel, 2013).

Social implications for understanding the cultural beliefs of this ethnically diverse population involve how to better understand their mental health help-seeking, assessment, and treatment needs. This chapter includes background and research on mental health help-seeking and treatment for minority immigrant populations. This is followed by the problem statement, purpose of the study, research questions, theoretical frameworks, and critical definitions, as well as a discussion of assumptions, scope and delimitations, and design limitations. The chapter concludes with a statement of potential social change significance, summary, and transition to Chapter 2.

Background

The majority of African immigrants came to the Unites States as foreign students during the early 1920s. This changed drastically during the early 1990s, that most African immigrants were coming to the U.S. as refugees to seek better conditions of living and religious freedom. The United States Census Bureau (USCB, 2010) said the number of African immigrants living in the U.S. increased from 881,300 in 2002 to 1.9 million in 2011. About 75% were Black, 19% were Arabs (mostly White) from the northern region of Africa (Immigration Policy Center (IPC), 2012; McCabe, 2011; Ross-Sheriff & Moss-Knight, 2013).

Most Africans brought with them their cultural beliefs influenced views of mental health, mental illness, and help-seeking which are distinctly different from normative U.S. perspectives, resources, and interventions (Amri & Bemak, 2013; Amuyunzu-Nyamongo, 2013; Hirschman, 2015). African cultures consider spiritual phenomena as fundamental to success and wellbeing in life. Religious beliefs include the notion that individuals who pass away transform into ascended masters and unseen ancestral spirits who involve themselves in daily affairs, including protection from evil forces, good fortune, success during day-to-day undertakings, marital relationships, and prevention of mental illness (Aina & Morakinyo, 2011; Akomolafe, 2012). Mental illness is viewed as spiritual possession or beliefs that animals, aliens, demons, extraterrestrials, gods, idols, or spirits can take control of a human body. Individuals experiencing mental illness may be dangers to themselves, others and law enforcement officers. Perceived sorcery is often

assigned responsibility for loss of personal resources, family, and friends (Aina, 2004; Aina & Morakinyo, 2011).

American mental healthcare systems (AMHCSs) do not recognize the unique challenges of African immigrants (Monteiro, Ndiaye, Blanas, & Ba, 2014). Individuals who belong to ethnically diverse minority population groups including African immigrants receive less treatment than their White counterparts, even though the demand for mental healthcare services is comparable (Amuyunzu-Nyamongo, 2013; Bauldry & Szaflarski, 2017; Hirschman, 2015). Language dissimilarities and communication impediments, distrust of American Mental Health Care System (AMHCS), higher rates of health coverage, and financial hardship are main explanations offered by ethnic and racial minorities for not seeking treatment (Wasem, 2014).

Many Africans do not recognize the U.S. mental health system's conceptualization of mental illness as contextually and biologically based. Conditions like posttraumatic stress disorder (PTSD), depression, major depression, attention deficit hyperactivity disorder (ADHD), and youth suicide are thought to be treated by African traditional medicine practitioners (ATMPs) and African indigenous spiritual healers (AISH). Such treatment includes purification rituals, exorcism reliefs, propitiation, supernatural counterattack, use of herbal remedies, spiritual healing, and magical practices (Aina, 2004; Aina & Morakinyo, 2011; Akomolafe, 2012; Ventevogel, Jordans, Eris, & Jong, 2013).

Country-of-origin beliefs can become obstacles to appropriate help-seeking in terms of mental health concerns (Amuyunzu-Nyamongo, 2013; Lindingeran-Sternart,

2015; Myers & Speight, 2010). Africans may be unwilling to talk about mental health, mental illness, and help-seeking because of their mistrust of Western health approaches, which they believe do not work because approaches lack consideration of cultural beliefs (Campbell & Long, 2014; Oluwatoyosi, Kimbrough, Obafemi, & Strack, 2014; Perciasepe & Cabassa, 2013). However, this has not been studied from a qualitative experiential perspective.

A further complication is cultural ignominy and stigmatization of mental illness (Aina & Morakinyo, 2011; Akomolafe, 2012; Amuyunzu-Nyamongo, 2013). Africans with mental illness are assumed to be crazy, suffering from a condition that has no cure. In most African countries, families with mentally ill relatives keep them at home, fearing embarrassment and humiliation (Sam & Moreira, 2012; St. Louis & Roberts, 2013; Ventevogel et al., 2013). Stigma, discrimination, prejudice, and shame can lead to disgrace and involve risks for such individuals, making it impossible for them to report mental illness symptoms and seek treatment in African cultures (Amuyunzu-Nyamongo, 2013; Padayachee & Laher, 2014).

Individuals with mental illness are not permitted in public gatherings and have limited access to education, affordable housing, and employment. Their ability to interact socially is limited, as they are marginalized because they are claimed to be crazy and dangerous. Family members and advocates may also be stigmatized and discriminated against without consideration (Akomolafe, 2012; Amuyunzu-Nyamongo, 2013; Padayachee & Laher, 2014). As the influx of African immigrants continues to rise (Chung, Bemak, & Grabosky, 2011; Kabuiku, 2017; Thomas, 2011), so does resistance to

seeking treatment because of perceived stigma. However, most literature documenting these phenomena is journalistic, anecdotal, or policy based. Formal studies of the meaning of mental health, mental illness, and help-seeking are needed to scientifically document the experiences of this immigrant group. In sum, there is considerable research on mental health help-seeking in immigrant populations, as well as relationships between perceived stigma and mental health-seeking. However, unique challenges and constraints experienced by African immigrants regarding the meaning of mental health, mental illness, and help-seeking have not been intensively investigated from a qualitative perspective.

Problem Statement

While there have been numerous policy studies and conceptual papers describing how cultural beliefs influence conceptualization of mental health and help-seeking among African immigrants, there is little research that has systematically examined experiences involving mental health, mental illness, and help-seeking among African immigrants in the U.S. The rate of refusal is higher and the rate of seeking treatment is lower compared with other minority immigrant population groups in the U.S. (Giacco, Matanov, & Priebe, 2014; Hacker, Anies, & Zallman, 2015; Leong & Kalibatseva, 2011; Perciasepe & Cabassa, 2013; Renner & Salem, 2014; Suphanchaimat, Kantamturapoj, Putthasri, & Prakongsai, 2015). However, what is missing is an understanding of beliefs, experiences, and perceptions that underlie how mental health and mental illness is constructed, and how help-seeking experiences occur in their new homeland. Therefore, the proposed

research will contribute to understanding African immigrants' lived experience of mental health and mental illness and the role of stigma during the help-seeking process.

Purpose of the Study

The purpose of the proposed qualitative research was to explore the lived experience of mental health, mental illness, and help-seeking among African immigrants in the U.S. The phenomena of interest were mental health, mental illness, and mental health help-seeking.

Research Questions

RQ1: What is the lived experience of mental health for African immigrants in the U.S.?

RQ2: How does indigenous cultural stigma occur in the meaning of mental illness?

RQ3: How do African immigrants in the U.S. describe their help-seeking experiences?

RQ4: How does indigenous cultural stigma occur in help-seeking?

Theoretical Frameworks

Two theories were proposed as theoretical frameworks to guide the development of the design interview questions and analysis. These were the segmented assimilation theory (SAT) and the cultural risk theory (CRT).

SAT

The SAT is widely used in psychological research studies to examine immigrant population groups. Specifically, the theory involves identifying appropriate structural, cultural, and social contributing factors that differentiate patterns of successful and unsuccessful assimilation that immigrant population groups go through in different host countries, including the U.S. (Fleischmann & Verkuyten, 2015). Some immigrants may

have higher mobility in terms of being accepted by the mainstream culture of their host countries, and this may be rewarded with better social and economic benefits (Amri & Bemak, 2013; Hacker et al., 2015). Other immigrants may not have such opportunities because of racial, ethnic, or religious discrimination, which leads to higher risks for poverty and suffering (Amri & Bemak, 2013). These differences in terms of assimilation success can occur within a single immigrant group and are affected by factors such as kinship, family ties, and social support (Zhou, 2014). Developing interview questions to explore unique experiences and issues involving families and the SAT will guide this study.

CRT

The CRT begins with the assumption that reality is socially constructed, and culture is the shared vision of that social reality that makes it work. The concept of cultural risk suggests that adverse events can happen because of moral or cultural transgressions and cures or changes are culturally determined (Bagasra & Mackinem, 2014; Ciftci, 2013; Shiraev & Levy, 2010; Tansey & Rayner, 2008). This theory has been used to test hypotheses and examine mental illness and barriers to seeking mental illness treatment, especially among ethnically diverse minority and vulnerable immigrant population groups.

Theories' Relation to the Study Approach and Research Questions

It is essential to recognize and explore how persons experience and struggle with quality of life and livelihood issues. Specifically, the SAT concepts that were applied in the proposed study included questions about acculturation and socioeconomic mobility to

understand experiences involving mental health and help-seeking. Cultural cognition, which involves how people frame their beliefs concerning the public, personal dangers that strengthen their responsibilities to each other, and collective understanding of that risk and impact on behavioral choices (Douglas & Wildavsky, 1982; Knudtzon, 2013; Shiraev & Levy, 2010). It may be that African immigrants who have had relatives diagnosed with mental health conditions in their home country and have experienced exclusion, prejudice, and ostracism from their community may be resistant to seeking help for fear that seeking help in their new home country will lead to further isolation. Participants were asked to explore prior and current help-seeking experiences and describe how their beliefs about help-seeking influenced their attitudes, feelings, and actions.

Nature of the Study

Interpretative Phenomenological Analysis (IPA) is proposed as the approach for the proposed research because it examines the meaning that individuals make out of their lived experiences (Smith, Flowers, & Larkin, 2009). IPA is derived from phenomenology, hermeneutics, and idiographic philosophical concepts and emphasizes that researchers should focus on the whole experience while searching for and listening to lived experience of the phenomenon from the participants' descriptions (Chan et al., 2013; Smith et al., 2009; Yuksel & Yildirm, 2015). The other unique aspect of IPA is the emphasis of the research process as dynamic and involves both participant and researcher. Referred to this as a "double hermeneutic"; i.e., observing how the participant is making sense of his/her world, and how the researcher is trying to make sense of the

participant's efforts (e.g., "What is the participant trying to achieve?"). This stance was particularly crucial in the effort to explore how participants make sense of their mental health and help-seeking experiences.

Purposeful homogeneous snowball sampling was used to recruit eight to 12 African immigrants in the U.S. who have experienced mental health issues, mental illness, and help-seeking in terms of indigenous cultural barriers. A sample size of eight to 12 was recommended for IPA studies. Semi-structured first-person-interviews with participants were conducted using an interview guide that was developed using fundamental concepts from the literature (see Appendix C). These included the SAT and CRT.

Brief Summary of the Methodology

IPA involves use of semi-structured and one-to-one interview procedures to attain narratives, reflections, thoughts, and reactions from research participants (Smith et al., 2009). These interviews require facilitating a natural flow of conversation and including vital questions and probing follow ups that include questions about sensory perceptions, memories, and personal interpretations (Pietkiewiez & Smith, 2014). NVivo was used for the management and organization of data and facilitated the organization of transcribed data into categories and themes that were interpreted and shared with participants.

Definitions

Acculturation: The process of assuming cultural qualities or social manners of a different ethnic group or culture (Rogers-Sirin, Melendez, Refano, & Zegarra, 2015).

Acculturative stress: Stress caused by the acculturation process as immigrants attempt to learn and adapt to the social manners of their host country (Rogers-Sirin et al., 2014). Despite challenging and complex social and psychological demands of acculturation, most immigrants find it to be meaningful and advantageous (Rogers-Sirin et al., 2014).

African Americans: Individuals who are citizens and residents of the U.S. with African ancestry or shared origins within one of the Black population groups of Africa (Myers & Speight, 2010).

African immigrants: Individuals who migrated willingly from their native African countries to live permanently in the U.S. African immigrants come to the U.S. with distinctive cultural perceptions. Additionally, they share similar African ancestry with most African Americans (Bhugra & Becker, 2005; Myers & Speight, 2010).

African native doctors: Traditional medicine practitioners in African cultures with no formal education or Western medical training. They use culturally-based treatments that are useful for individuals with mental illness (Akomolafe, 2012; Leighton & Hughes, 2005).

African spiritual or faith healers: Individuals who use prayer and spiritual cleansing as a culturally-based treatment for mental illness (Akomolafe, 2012; Leighton & Hughes, 2005).

Culture: An expression of an individual's way of life, illustrated by behaviors, traditions, ideology, customs, and attitudes (Leong & Kalibatseva, 2011; Shiraev & Levy, 2010).

Ethnicity: A group of individuals connected by specific cultural beliefs and shared heritage (Leong & Kalibatseva, 2011; Shiraev & Levy, 2010).

Assumptions

As a qualitative researcher, the investigator was the primary research tool for collecting, transcribing, and analyzing data. It was assumed that participants in the research had ample opportunity to truthfully share their experiences to generate rich, thick descriptions about their relevant experiences. Another assumption was that interviews with selected samples of African immigrants would be adequate to attain saturation and results would be specifically generalizable to all African immigrants. Investigator put aside personal biases, preconceived concepts, and culturally-influenced notions concerning mental health to be fully present and aware of stories and meanings of participants. I tried to address and attempted to reduce the influence of bias by implementing appropriate steps to ensure the trustworthiness of data and focus on credibility, transferability, dependability, and confirmability.

Scope and Delimitations

Participants in the research were limited to individuals who had experienced mental health disorders, mental illness, and help-seeking and were currently living in a large West Coast urban area that supports a vital and prominent African immigrant community. Other areas of the U.S. were not sampled. Participation in the proposed research was limited to African immigrants 21 years and older from the five main regions of Africa. African immigrant participants who are younger may exhibit challenging developmental complications that may exceed the scope of the proposed research.

Individuals from other ethnically diverse minority immigrant population groups in the U.S. did not fall within the purview of this proposed research. Participants had lived in the U.S. for at least one year and were willing to talk about their lived experiences. All participants were fully informed of the nature of their participation and signed informed consent forms (see Appendix B).

There has been considerable discussion across many disciplines regarding the nature of assimilation, acculturation, and integration of racial, ethnic, and religious groups in the U.S. While political and policy discussions tend to focus on questions of acceptance, tolerance, and diversity, social scientists have focused on how unique country-of-origin characteristics can facilitate or detract from quality of life and socioeconomic wellbeing (Schneider & Crul, 2010). Assimilation across and within immigrant populations was relatively consistent and monotonic (Gordon, 1964). Investigator chose the SAT and CRT as theoretical frameworks. Other theories that proposed linear and monotonic approaches were not chosen.

The target group for the proposed research was African immigrants who have mental health, mental illness, and help-seeking lived experiences in the U.S. Most African immigrants in the U.S. prefer to live in large metropolitan settings, and most have settled in Washington, DC, New York, Georgia, Texas, Maryland, Virginia, Massachusetts, Pennsylvania, and California (Immigration Policy Center [IPC], 2012). In IPA research, individuals selected to participate in the research represent the phenomenon of interest rather than the population under study (Smith, 2011; Smith et al., 2009). Therefore, individuals selected to be interviewed were able to provide descriptions of

lived experiences in terms of the phenomenon under study. Furthermore, all participants were required to be fluent in the English language as stipulated by participant inclusion and exclusion criteria.

Limitations

The quality of the research was dependent upon access to enough individuals who met the criteria for inclusion and could provide rich, thick descriptions of their experiences with mental health, mental illness, and help-seeking experiences. A purposeful and homogeneous sample was used through the combination of referral and snowball sampling of African immigrants who have experienced mental illness and help-seeking. It was hoped that this process would enable saturation, although a bigger sample size may have been able to generate additional differing data.

To enhance transferability, I provided explanations of procedures for data gathering, analysis, and interpretation. I described settings, research design, methodology, and participants with complete information in order to be transferable to other groups and contexts. I enhanced transferability using rich descriptions for establishing credibility in qualitative research.

To enhance dependability, I consulted with methodology and content experts to evaluate the interview and research questions. Additionally, I asked participants to review a summary of their transcripts as part of the member-checking process and recorded comments and reflections during all parts of data collection and analysis as part of an audit trail process.

Significance

The study will contribute to scholarly literature regarding African immigrants by providing more contextual and detailed information concerning their experience with mental health, mental illness, and help-seeking. It will lead to comprehensive information regarding African immigrants' experiences with mental health, mental illness, meaning of help-seeking experiences, occurrence of indigenous stigma in mental health, occurrence of indigenous stigma in mental illness, the occurrence of indigenous stigma during help-seeking experiences, and other experiences of participants. The study was conducted in a conducive and advantageous setting in order for participants to reflect on their lived experiences while reviewing their deepest feelings. It is a goal of this study to explain how different cultural beliefs are experienced in a foreign country, particularly regarding interacting with established and culturally different processes involving managing risks and problems. The results of this research may provide rigorous and meaningful recommendations for policy and practice. Many African immigrants believe that mainstream Western and American mental healthcare services cannot efficiently respond to their problems (Amuyunzu-Nyamongo, 2013; Ciftci, 2013; Corrigan et al., 2014). Therefore, understanding of these phenomena could lead to the development of more sensitive intake and treatment systems for culturally unique persons. The findings of this study suggest that African immigrants' mental health, mental illness, and help-seeking needs are fundamental in terms of maintaining good health and wellbeing. The following are recommendations for comprehensive improvement:

- Providing appropriate information to mental health clinicians and researchers concerning possible impediments for African immigrants and instructing them to obtain necessary information from African immigrants regarding trust in terms of help-seeking for mental health problems and illnesses.
- Encouraging recruitment and training of psychologists who understand African immigrants and come from the same cultural background.
- Establishing community mental health programs (CMHPs) within community health centers (CHCs) that offer culturally-appropriate information to African immigrants concerning mental health, mental illness, help-seeking, recovery, wellness, rehabilitation, and available modalities of treatment.
- Amalgamating primary healthcare services and mental healthcare services through community public health partnerships for African immigrants.

Summary

This chapter included an overview of research. Background information discussed in this chapter was given to provide specifics regarding the gap in knowledge. The problem statement illustrated that the challenges of African immigrants' cultural beliefs regarding mental health, mental illness and help-seeking which have not been examined by researchers. The purpose of the research and theoretical framework that guided the study was documented in this chapter. Primary terminologies that were used in the research were also reviewed. Significance of the research was also established in this chapter. A literature review is presented in Chapter 2.

Chapter 2: Literature Review

The purpose of this study was to explore African immigrants' the lived experience of mental health, mental illness, and help-seeking in the U.S. This chapter explains the literature search strategy, literature regarding the theoretical framework, and available empirical studies. This includes studies that describe how African immigrants in the U.S. share a cultural ideology that attributes mental illness problems to supernatural causative factors which then must be cured through culture-specific interventions and how this contrasts with Western methods of assessment, diagnosis, and intervention. Lack of culture-sensitive processes plus cultural stigmatization associated with mental illness reduces opportunities for African immigrants with mental health problems to get appropriate care (Chukwuemeka, 2009; Mori et al., 2007). This chapter contains an introduction, literature search strategies, information about the theoretical framework, and a literature review related to fundamental concepts, as well as a summary and conclusion.

Literature Search Strategy

Psychology databases such as PsychARTICLES, PsychINFO, PsychEXTRA, SocINDEX with Full Text, Academic Search Complete, Primary Search, PsycBooks, and PsychCRITIQUES were accessed using the following search terms: *assimilation*, *acculturation stress*, *Africans*, *African Americans*, *African immigrants*, *American Muslim immigrants*, *African native doctors*, and *African spiritual or faith healers*.

Theoretical Framework

Two theories were proposed as theoretical frameworks to guide the development of the design interview questions and analysis. These were the SAT and CRT. There has been a considerable discussion across many disciplines regarding the nature of assimilation, acculturation, and integration of racial, ethnic and religious groups to the U.S. (Kivisto, 2015). While political and policy discussions tend to focus on questions of acceptance, tolerance, and diversity, social science theories have focused on how unique country-of-origin characteristics can facilitate or detract from the quality of life and socio-economic well-being (Schneider & Crul, 2010). Most current are the frameworks that do not presume a "monotonic, upward social mobility trajectory" across and within the immigrant population typical of classic immigration theory (Gordon, 1964). Instead, modern theories incorporate culture-of-origin and assimilation factors that put some individuals and groups at higher risk (Akresh et al., 2016). The proposed research employed segmented assimilation theory and cultural theory of risk (Amri & Bemak, 2013; Viruell-Fuentes et al., 2012). Both theories propose constructs and hypotheses that frame how immigrant individuals take divergent pathways towards health and mental health, as well as socio-economic integration (Fleischmann & Verkuyten, 2015; Yuksel & Yildirm, 2015). A discussion of segmented assimilation theory and cultural theory follows below.

SAT

Segmented assimilation theory, as formulated by Portes and Zhou (1993), was developed as an alternative to other models of assimilation theories because of their

inability to further researchers' understanding of the relevant issues pertaining to modern assimilation patterns, socioeconomic barriers, acculturation stress, racial discrimination, and mental health problems (Viruell-Fuentes et al., 2012; (Portes & Zhou, 1993). The segmented assimilation theory focuses on the circumstances (e.g., cultural bias, socioeconomic barriers, acculturation stress, and assimilation issues) that could lead to deterioration or improvement in health and wellbeing. Socioeconomic context modifies the relationship between assimilation and physical health. Fox, Thayer, and Wadhwa (2017) said factors like social support and community cultural orientation could moderate the extent to which immigrants maintain their mental and physical health status.

Stressful familial arrangements that challenge immigrant families include single parents raising children, children with no fathers, increasing rates of female-headed households in addition to increasing occurrence of domestic violence and emotional abuse, alcohol and drug abuse, and social and economic problems (Akresh et al., 2016; Fox et al., 2017; Shishehgar et al., 2015). The There are two different assimilation paths for second generation African immigrants . The first assimilation path is an upward mobility process that makes it possible for second generations of African migrants to attain higher social and economic status, employment opportunities, affordable housing, suitable marital partner, and families, resembling majority White American lifestyles (Okonofua, 2013; Fleischmann & Verkuyten, 2015). The second assimilation path is a descending process that leads to continuous suffering and reduced quality of life, low social and economic status, language barriers, academic and professional deficiencies, unemployment, affordable housing problems, dysfunctional family structures, and

marginalization caused by racism and cultural discrimination, all of which are contributing factors to acculturation stress and mental illness problems.

CRT

The CRT is the second theory that guided the proposed research. The CRT originated from the work of Douglas and Wildavsky; it has since become a dominant theoretical framework that is used in psychological research studies to examine culturally-related concepts of mental illness and barriers that prevent individuals from seeking mental illness treatment (Schock-Giordano, 2013; Shiraev & Levy, 2010). The CRT is a theoretical framework for understanding sociocultural factors that shape traditional beliefs of African immigrants.

The theory proposes that social consciousness and culture determine the concept of risk, or what is acceptable and not acceptable. According to Douglas and Wildavsky (1982), "The different social principles that guide behavior affect the judgment of what dangers should be most feared, what risks are worth taking and who should be allowed to take them" (p. 6). There are three common factors that shape understanding of how cultural concepts influence perceptions of mental illnesses and mental illness treatments: cultural concepts that influence how mental illness symptoms are expressed among group members, cultural concepts that influence contributory factors of mental illness, and cultural implications that negatively impact willingness to seek mental illness treatment (Leong & Kalibatseva, 2011; Schock-Giordano, 2013). This theoretical framework has been used to determine the influence of culturally-related factors on mental illness and mental illness treatment. Sam and Moreira (2012) said cultural factors play a significant

role in shaping the ethnically diverse minority immigrant population groups' attitudes and perceptions concerning mental illness and treatment and should be carefully considered by mental health clinicians and researchers in developing and providing culturally sensitive and acceptable mental illness interventions to ethnically diverse minority population groups in the U.S.

Relationship of Frameworks to the Proposed Study

The proposed research involved the SAT and CRT. Both theories propose constructs and hypotheses that frame how immigrant individuals take divergent pathways towards health and mental health, as well as socio-economic integration (Fleischmann & Verkuyten, 2015; Yuksel & Yildirm, 2015). The segmented assimilation theory recognizes that assimilation and living in a new culture can take many different paths and that it is essential to recognize and explore how persons experience and struggle with the quality of life and livelihood issues. Specifically, the segmented assimilation theory concepts that were applied in the proposed study included questions about acculturation and socioeconomic mobility to understand the experience of mental health and help-seeking (Akresh et al., 2016; Portes & Zhou, 1993). The fundamental concept of the cultural theory of risk is cultural cognition (Douglas & Wildavsky, 1982; Knudtzon, 2013; Shiraev & Levy, 2010). This concept describes how people frame their beliefs concerning the public and personal dangers that strengthen their responsibilities to each other, and the collective understanding of that risk and impact on their behavioral choices (Douglas & Wildavsky, 1982). For example, it may be that African immigrants who have had relatives diagnosed with mental health conditions in their home country (and have

experienced exclusion, prejudice, and ostracism from their community) may be resistant to seeking help for fear that seeking help in their new home country will lead to further isolation. This concept will be utilized in the development of the interview guide and analysis plan to answer the research questions.

Literature Review Related to the Key Concepts

African Migration to the U.S.

The current developments in the African migration to the U.S. differ from the trans-Atlantic calamitous slave-trade when Africans were forcefully brought against their wishes to the U.S. as migrants in the early 16th to 19th centuries to work in the plantations with no human rights (IPC, 2012; McCabe, 2011; Solomon, 2017). Voluntary immigration to the U.S. commenced in the late 1980s and progressed through 2009 to the present, with a significant influx of African immigrants from different countries in the Five Main Regions of Africa (IPC, 2012; McCabe, 2011). The population of African immigrants living in the U.S. increased from below 200,000 in 2002 to approximately 1.9 million in 2016. Currently, the total population of African immigrants to the U.S. has increased to 1.9 million, and by ratio is, "(3.9 %) by the mounting share of the U.S. 38.5 million immigrants from different worldwide countries" (McCabe, 2011, p. 1). During early 2010, the number of immigrants from other countries including African immigrants living in the U.S. was estimated to be 40 million. This number will continue to grow as more African immigrants arrive in the U.S., as will immigrants' problems that include mental health, mental illness, and help-seeking (Hirschman, 2015; IPC, 2012; McCabe, 2011; Solomon, 2017).

Ross-Sheriff and Moss-Knight (2013) studied two groups of African immigrants - refugees and legal immigrants. The distinguishing characteristics of the recent African immigrants to the U.S. are that they attain higher academic degrees, higher English proficiency level and have lower unemployment rates than immigrant population groups from other countries. According to Ross-Sheriff and Moss-Knight (2013):

> New York, California, Texas, Maryland, New Jersey, Virginia, Georgia, and Massachusetts are the eight states that are selected destination locations by black African immigrants and gravitate more to states with a significant number of other black residents where they settle in large numbers and establish ethnic enclaves. (p. 5)

Based on their cultural beliefs, collectivist tendencies, and traditional commitment to family orientation, African immigrants who are established in the U.S. help new immigrants from their native countries, family units, tribal, ethnic, religious groups, and social network to find affordable housing and employment and tend to localize to these geographic regions (Ross-Sheriff & Moss-Knight, 2013).

Acculturation of Immigrants to Life in the U.S.

Acculturation in context of immigration refers to the process of, "cultural contact and exchange through which a person or group come to adopt certain values and practices of a culture that is not originally their own, to a greater or lesser extent" (Cole, 2018, p. 1). Recently, two articles, (Fox et al., 2017, 2017a, 2017b) extensively reviewed the literature and proposed a model that established the importance of acculturation (successful and unsuccessful) in understanding overall health, mental health, and health

disparities among minority populations. How immigrants adopt characteristics of the host cultural beliefs, values, and attitudes, either consciously or unconsciously can lead to successful acculturation or the adoption of harmful behaviors.

These sources found many characteristics appropriate to acculturation together with neighborhood ethnocultural composition, discrimination, discrepancy between origin and host environments, inconsistency involving heritage and host cultures, origin group, host group, individual attitudes towards assimilation, variation in targets of assimilation within host community, public policy, resources, and migration selection prejudice. Established that, the most challenging system of acculturation process was assimilation, characterized by the acquirement of host cultural beliefs together with the hammering of inheritance cultural beliefs. Ndika (2013) established that immigrants living in pluralistic cultures might have to create an assortment of acculturation strategies through which they deal with and muddle through with the multi-cultural conditions of the individuals with whom they interact.

Challenges to African Immigrants' Acculturation

Migration and challenges of acculturation experience of African immigrants to the U.S. broaden the scope of the proposed investigation (Kasturi, Iyengar, & Haile, 2014). The following studies, Conner et al. (2010), Leong and Kalibatseva (2011), and Renner and Salem (2014) found that, "the challenges of migration to the U.S. and complicated acculturation experience of African immigrants would aggravate mental health, mental illness, and help-seeking problems (Conner et al., 2010; Leong & Kalibatseva, 2011; Lindinger-Sternart, 2015; Renner & Salem, 2014). Kasturi et al. (2014) confirmed that

this is somewhat surprising given that African immigrants are a significant part of the emergent ethnically diverse minority population group with continuous future emigration to the U.S. However, a closer look at cultural beliefs specific to mental health, mental illness and help-seeking illuminate why the risk to mental health can increase.

Culturally Relevant Mental Health Care for African Immigrants

According to Ross-Sheriff and Moss-Knight (2013), the availability of culturally relevant and useful mental health care services for African immigrants is inconsistent and potentially inadequate. The primary obstacle to availability is the lack of culturally acceptable mental health practices. Several studies have found that social inequality, racial discrimination, and prejudice are ongoing problems that affect African immigrants in the U.S. mental health system (Mori et al., 2007). Previous qualitative research has demonstrated through interviews and observations of ethnic minorities that individuals seeking treatment often experienced barriers to accessing treatment and turned towards more culturally and emotional supportive methods of care (Conner et al., 2010; Lindinger-Sternart, 2015; Padayachee & Laher, 2014; Renner & Salem, 2014); and the lack of culturally appropriate resources make it difficult for mental health clinicians and to develop and offer adequate mental health services (Kabir, Illiyasu, Abubakar, & Aliyu, 2004; Leong & Kalibatseva, 2011; Ngo, 2008).

Mental Health

Ethnically diverse minority population groups like African immigrant's experience and interpret mental health, mental illness, and interventions differently (Amuyunzu-Nyamongo, 2013; Bagasra & Mackinem, 2014; Ciftci, 2013). Many

international organizations have studied and provided physical and mental health resources and services to African countries in efforts to improve lives. Within American medical system, the terminology characterized as mental health is collectively utilized in allusion to mental illness. Mental health and mental illness remain as connected phenomena individually but demonstrate different psychological conditions among individuals (Glide & Frank, 2016; Gureje & Stein, 2012). Mental health is defined as the "state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and be able to make contributions to his or her community" (Center for Disease Control and Prevention [CDC], 2013, p. 1). There is a general approximation that no more than, "17% of U. S. adults are considered to be in a state of optimal mental health" (CDC, 2013, p. 1).

More broadly defined, mental health is regarding the ability to perform mental and cognitive functions successfully, complete productive daily activities, maintain rewarding relationships with other individuals, and gain adaptive capacity to change and deal with adversities (CDC, 2013; Glide & Frank, 2016; Gureje & Stein, 2012). Amuyunzu-Nyamongo (2013) described mental health as a socially defined construct, and that it is a taboo subject that attracts stigma. Mental health is also profoundly affected by war, poverty, and other significant disasters: Amuyunzu-Nyamongo (2013) said, "there is a correlation between the level of mental health in a community and general level of social well-being" (p. 59). To further complicate the lack of access and resources, African cultures consider spiritual phenomenon as fundamental to success and well-being in life, believing that individuals who passed away transform into ascended-masters,

unseen ancestral spirits who involve themselves in the daily affairs, including self-protection from evil forces, good fortune, success in day to day undertakings, marital relationships, and prevention of mental illness (Aina & Morakinyo, 2011; Akomolafe, 2012; Perciasepe & Cabassa, 2013). For example, a study described "a variety of cultures in West Africa but with prominent similarities in customs, and beliefs, dress, food, music, religion, etc. hence one may talk of a West African culture that is different from other parts of the world" (Aina & Morakinyo, 2011, p. 2).

These researchers conducted a wide-ranging search for literature with connected relevance to culture-bound syndromes in West Africa, initiated personal contacts, and conducted individual interviews with medical and mental health clinicians in the West Africa sub-region to collect the required data. They emphasized that four mental health disorders, including "The Brain Fag Syndrome (TBFS), Koro and Koro-like (Magical penis loss), Ode On and Ogun Oru, and the so-called culture-bound concepts (CBCs) such as Abiku or ogbanje and pobough Lang" (p. 3), deemed to meet the criteria for culture-bound syndrome (CBS) were documented to have been identified in West Africa.

Akomolafe (2012) asserted that psychological assessments, established diagnoses, and treatments are mental health constructs shaped by Western hegemonic perceptions which are drastically in contrast with the traditional beliefs and practices of ethnically diverse groups, thereby causing a crisis condition for the groups not represented by Western assertions. The author found that indigenous understanding platforms in mental health healing and wellbeing are well-informed by the notion that offering indigenous individuals mental health treatment from a non-indigenous perspective is an understated

form of colonialism and oppression as it does not recognize their worldviews or treat cosmologies as legitimate in their rights with the existence of different ethnic groups within the society formulation and distribution for a mental health care system that will not benefit one model more than other models.

Perciasepe and Cabassa (2013) literature review summarized negative attitudes on mental illness from 34 public-based studies that explored the public stigma of mental illness. The authors found out that, mental illness stigma involve undervaluing, humiliating and disrespecting individuals with mental illness by the general population. There are preconceived negative attitudes concerning the dangerousness of individuals with mental health and mental illness problems that expand with rapidity over time. These negative attitudes include embarrassment, humiliation, blameworthiness, incompetency, chastisement, punishment, and established criminality of individuals diagnosed with mental disorders. Additionally, that stigmatization attitudes, stigmatization actions, and stigmatization beliefs differ significantly among the categories of mental illness diagnoses, mental health problems, socio-economic conditions, and demographic characteristics (Perciasepe & Cabassa, 2013). Precisely, the sensitivities and perceptions of dangerousness among individuals with mental illness and contributory factors are known to be generally appropriate and vary based on the social environment (Parcesepe & Cabassa, 2013). Therefore, mental health is seen because of being in good stead with the invisible forces that support the ability to be productive in work and relationships and function to solve the problems of daily life (Parcesepe & Cabassa, 2013).

Mental Illness

In the U.S., the definition and assessment of mental health problems evolved through the paradigm of scientific method and had been codified and described in regularly peer-reviewed compendiums like the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 2013; Glied & Frank, 2016; Gureje & Stein, 2012). The concept of mental disorder is like the other conceptions in medical science, in that clarification and acceptance of diagnostic categories require an ongoing operational clarification that covers all conditions (APA, 2013). American mental health and medical system perspectives emphasized that mental illness is a physical condition within the category that comprises. Glied and Frank (2016) found the following:

> A vast number of conditions (schizophrenia, bipolar disorder, depression, anxiety disorder, dissociative disorders, posttraumatic stress disorder (PTSD), obsessive-compulsive disorder, borderline personality (BPD), and schizoaffective disorder among others) have a wide range of effects on individuals experiencing those conditions, such as social withdrawal, limits on functioning, work, parenting, cognitive impairments, troubling behavior, and in some cases violent behavior. (p. 545).

While some mental illness does not have a final biological assessment, these classifications of mental illnesses are conditions which are overwhelmingly disabling, and which significantly impede in daily living functioning abilities.

Some mental illnesses occur intermittently, some are unremitting (example, many individuals diagnosed with depression stand a chance of 50% recurrence), and some are single event experiences (Glied & Frank, 2016). In contrast, the African immigrant perspective sees the onset of mental illness as sourced in spiritual "possession" (i.e., they believe that animals, aliens, demons, extraterrestrials, gods, idols, or spirits can take control of a human body). Individuals experiencing a spirit possession may progress to danger to self, others, contact with the law and confrontation with law enforcement officers. The perceived sorcery is assigned responsibility for loss of personal resources, family, and friends (Aina, 2004; Aina & Morakinyo, 2011; Parcesepe & Cabassa, 2013).

Africans may be unwilling to talk about mental health, mental illness, and help-seeking because of their mistrust of Western physical and mental health approaches which they believe will not work because they lack consideration of their cultural beliefs (Campbell & Long, 2014; Oluwatoyosi, Kimbrough, Obafemi, & Strack, 2014; Parcesepe & Cabassa, 2013). For example, Campbell and Long (2014) said that, while the help-seeking behaviors and mental health service use among African Americans are affected by various factors, the significance of culture and culturally informed beliefs and notions of mental health, mental illness, and help-seeking must be recognized in their behaviors to seek treatment.

Oluwatoyosi, Kimbrough, Obafemi, and Strack (2014) said challenges in dietary acculturation (availability of healthy foods, limited access to occupations consistent with their country of origin, and challenges to cultural competence in navigating the health care system). In addition to dealing with the effects of illness, individuals are often

shunned or made an outcast in their communities. Amuyunzu-Nyamongo (2013) said girls from homes known to have mental illness are disadvantaged in marriage, which limits their opportunities for security qualitative of life.

Help-Seeking

The U.S. medical and mental health systems have evolved to make access to professional help more accessible and less intimidating (CDC , 2012; Glied & Frank, 2016; Hacker et al., 2015; Hwang, Myers, Abe-Kim, & Ting, 2008; Singh, Rodriguez-Lainz, & Kogan, 2013). Nevertheless, the decision and actions to seek help are still known to pose multiple barriers. The thought of seeking help may create personal distress more significant than the perception of the actual problem, thereby, reducing the chance of the person seeking help. Minority and immigrant population groups' attitudes towards mental health and mental illness help-seeking have been widely studied in the U.S. The negative thoughts "are associated with demographics and cultural characteristics that influence how much persons with psychological problems will avoid seeking help" (Vogel et al., 2007, p. 410). According to Amri and Bemak (2013), collectively with mistrust of U.S. mental health system and accessible mental health care treatments, African immigrants' help-seeking is impacted by the following: "Mental health service needs, cultural mistrust of mental health clinicians, social stigma of mental health problems and help-seeking, social stigma and cultural mistrust, trauma treatment, alcohol and poly-substance use and abuse, and family centered services" (p.47-51).

Despite access to Western (European and American) developed mental illness treatments, African immigrants may prefer to ask for assistance from immediate family

members, traditional medicine practitioners, faith and spiritual healers, and fortune-tellers to cure the manifesting mental illness symptoms (Lindinger-Sternart 2015; Renner & Salem, 2014). Attitudes of African immigrants concerning mental illness and European and American treatment may be influenced by these practices from their native countries (Lindinger-Sternart, 2015). Such treatment includes purification rituals; exorcism relieves, propitiation, supernatural counterattack, utilization of herbal remedies, spiritual healing, and magical practices (Aina, 2004; Aina & Morakinyo, 2011; Akomolafe, 2012; Ventevogel et al., 2013).

Derr (2017) said that non-immigrants have access to mental health services at a higher rate while immigrants have access to services at a lower rate. Also, there are significant uncertain mental health care demands and explanations associated with the use of services by immigrants.

Villatoro et al. (2014) said that family and culture influences are significant in exertions intended to know and enhance help-seeking behaviors and appropriate utilization of acceptable mental health care services by Latinos in the U.S. Venters and Gary (2009) said that the occurrence of mental health problems of African immigrants differs widely among published information. The healthcare necessities and practices of African immigrants continue to remain inadequately characterized. The significant impediment to understanding the health conditions and practices of African immigrants in the U.S. is the non-existence of accurate recording of national origin and language dissimilarities in medical care settings. Additionally, the utilization of different research-identifications for African immigrants, like African-born-black, foreign-born-black,

African-ancestral, and non-Caribbean-black influences data interpretation and assesses data from different studies entirely complicated.

Role of Stigma in the Mental Health Help-Seeking

While the understanding and acceptance of mental health and mental illness have evolved considerably over the past 50 years, there still exists, mainly in ethnic minority populations residing in the U.S., a social problem regarding the way individual families experience and cope with mentally unhealthy members (Mak, Chong, & Wong, 2014; Schock-Giordano, 2013). This problem is conceptualized as a stigma defined as, "devaluing, disgracing, and disfavoring by the general public of individuals with mental illnesses" (Abdullah & Brown, 2011, p. 2). The stigma of mental illness and treatment makes it difficult for people to seek mental illness treatment. Dale and Daniel (2013) said that ethnically diverse minority individuals, including African immigrants, are vulnerable to social discrimination, which might prohibit access to receiving quality mental health service.

Research on the Experience of Stigma

The stigma of mental illness is marked by stereotyping, shaming, dishonoring, disrespecting, and humiliating the ill person and his/her family, and is an ongoing problem (Quinn et al., 2015). The experience of stigma is magnified due to the mistrust of mental health clinicians and researchers from other cultures, mental health clinicians' lack of awareness concerning immigrants' sociocultural concepts of mental illness symptoms, language dissimilarities, and mistrust of treating mental illness with psychotherapy and pharmacotherapy (Quinn et al., 2015). African immigrants experience

poor outcomes against the number of primary social and mental health indicators; they are more likely to be given established diagnoses and are over-represented in inpatient mental health care services, confronted with racial prejudice and discriminated against by mental health clinicians.

Abdulla and Brown (2011) examined ethnocultural beliefs and stigma of mental illness. For example, although a few Native American Indian population groups abstain from the stigmatization of mental illness, the researchers found that most groups stigmatize just a few mental illnesses, and others conform to the practices that stigmatize all mental health problems and mental illnesses suffered by their tribal members. Among Asian cultures that emphasize traditional values with conformity to cultural norms, family acknowledgment through accomplishment and emotional self-control, stigmatization of mental illnesses is universally practiced because mental illnesses are assumed as sources of embarrassment. Carpenter-Song et al. (2010) explored help-seeking varied along ethnic-racial lines, with 25 African Americans, Latinos, and Euro-Americans diagnosed with a severe mental illness. Carpenter-Song et al. (2010) said:

> Euro-American participants were most similar in beliefs to the professional disease-oriented perspectives on severe mental illness and found it less stressful to seek mental health professionals. African American and Latino participants emphasized non-biomedical interpretations of behavioral, emotional, and cognitive problems and were critical of mental health services. (p. 1)

Clement et al. (2014) found that stigma was the fourth highest ranked barrier to help-seeking, with disclosure concerns the most reported stigma barrier, among ethnic

minority population groups. Link, Wells, Phelan, and Yang (2015) established the significance for understanding the emblematic communication stigma and the extent to which the beliefs concerning other individualistic reactions contribute to the complexity of stigma of mental illness. In another example, Mantovani, Pizzolati, and Edge (2017) found factors that influenced help-seeking behavior among African-descended individuals including beliefs about the causes of mental illness, silencing of mental illness resulting from heightened levels of ideological stigma, and stigma (re) production and maintenance at the community level. These sources established that these factors were likely to cause a triple danger in expressions of stigma in individuals struggling with mental health.

Quinn et al. (2015) explored the stigma of mental illness, by utilizing an ethnically diverse minority population group sample of participants with an established range of mental illness problems and experiences. While the authors used only the ethnically diverse sample, the participants were specially selected from low-income socio-economic backgrounds, and with less than a high school education. The authors found out that there was an emergent affirmation that equally internalized and anticipated stigmas influence the entire mental health care services, in addition to treatment utilization that encompasses acquiescence, interpersonal associations, and understanding of care, treatment commitment, treatment effectiveness, and cultural sensitivity.

Wong, Kong, Tu, and Frasso (2018) analyzed data from scales and narratives obtained from eight Chinese family-dyads and found that individuals identified with schizophrenia disorder and their caregivers equally internalized negative valuation from

their social networks and reduced commitment in the community. In sum, the causes of the stigma of mental illness are consistent across cultures and worldwide countries, however, Monteiro (2015) said, “while every country’s social and cultural realities are different, there are a number of underlying themes and evidence-based methods for using these actualities to contextualize appropriate guidelines for mental health care service” (p. 87).

Mantovani et al. (2016) did a qualitative study that investigated stigma connected with a mental illness involving, “faith-based African-descended communities in South London, locating the narratives of 26 interviewees within an interpretative framework constructed by the reading of the interdisciplinary literature on stigma” (p. 375). Results revealed that, “three key themes that emerged from the data, which were illustrated by direct quotes related to the following: beliefs about mental illness and production of stigma, the social consequences of stigma of mental illness, the impact of avoidance behavior on help-seeking, and the reproduction of stigma in faith communities” (Mantovani et al., 2016, p. 373).

St. Louis and Roberts (2013) revealed that mental illness is one of the most misconstrued conditions in African cultures, and the individuals who have mental illness are stigmatized and discriminated against. For example, in most African countries, families with mentally ill relatives keep them at home, fearing embarrassment and humiliation from the community (St. Louis & Roberts, 2013). These sources explored the public behaviors concerning mental illness in two extensively diverse cultures, Canada and Cameroon with 120 participants with mental illness. The results revealed that within

Canada and the U.S., behaviors were generally more encouraging and less commonly stigmatizing concerning mental illness in Cameroon. These fears serve as barriers that prevent individuals from African cultures from seeking professional treatment for mental illness (Bagasra & Mackinem, 2014). The stigma of mental illness is pervasive in African culture and is marked by the stereotyping, shaming, dishonoring disrespecting, and humiliation of individuals who have a mental illness (Quinn et al., 2015).

Summary and Conclusions

African immigrants undiagnosed and untreated mental illness problems in the U.S. are not usually recognized and addressed by mental health clinicians and researchers because despite access to the Western (European and American) modalities of mental illness treatments, African immigrants may instead seek assistance from close family members, traditional medicine practitioners, faith and spiritual healers, and fortune-tellers to cure the manifesting symptomatic complications of mental illness (Conner et al., 2010; Leong & Kalibatseva, 2011; Lindinger-Sternart, 2015; Renner & Salem, 2014). African immigrants have experienced challenging problems of racial discrimination, racial profiling, barriers to financial success, language differences, and adaptation of ways of life (Kasturi et al., 2014). These problems increase the potential for African immigrants to develop mental illnesses (Kasturi et al., 2014). There is a significant and confirmed rate of undiagnosed and untreated mental illness problems among African immigrants to the U.S. The recognized mental illnesses that are well-known among African immigrants include depression, anxiety, schizophrenia, bipolar disorder, depression, somatic

disorders, PTSD, suicidal ideation, and alcohol and chemical substance abuse and dependence (Kasturi et al., 2014).

The challenges of acculturation among African immigrants with undiagnosed and untreated mental illness remain unresolved. Socially and culturally related factors alone should not be utilized to explain these problems faced by migrants. Carefully considering discrimination and inequalities embedded within the mental illness treatments process should also be considered. Failing to resolve immigrants' mental illness problems and remove the barriers that prevent individuals from seeking mental illness treatment pose serious dangers to the whole nation and limits immigrants' access to effective mental healthcare services (Rogers-Sirin et al., 2015). Undiagnosed and untreated mental illness is a challenge for African immigrants. Migrating from one's country of birth to another country can become a traumatic and distressing experience (Rogers-Sirin et al., 2015). Specifically, transitioning to a new way of life in another culture involves a range of challenging issues including acculturation, barriers to financial success, and prejudices (Rogers-Sirin et al., 2015).

Migration has complicated issues that require careful consideration of the circumstances proceeding and following migration, such as family problems (Rogers-Sirin et al., 2015). When mental health clinicians and researchers fail to consider these relevant cultural factors, they are not able to develop and offer compelling and acceptable mental illness treatments for immigrants, including African immigrants to the U.S. Their inability, in turn, may adversely affect psychological assessment and lead to establishing incorrect diagnoses, stereotyping, and ineffective mental illness treatment outcomes

(Kasturi et al., 2014). A limited number of research studies have been conducted to examine migration and challenges of acculturation as contributing factors to mental illness problems of African immigrants. Even though the U.S. is a country that welcomes immigrants from different continents, no specific preparations have been made to facilitate mental health care services for immigrant populations, including African immigrants (Rogers-Sirin et al., 2015; Viruell-Fuentes et al., 2012). Immigrants must understand these immigration policies, must have financial resources to support themselves, must not become a public charge, and must fulfill the requirements to live in the U.S. as law-abiding immigrants (Viruell-Fuentes et al., 2012).

The SAT and CRT were discussed as the frameworks for illuminating the interview development and analysis process. Many African immigrants believe that the mainstream Western and American mental healthcare services cannot be efficiently responding to their problems (Ciftci, 2013; Corrigan et al., 2014). Therefore, understanding of these phenomena could lead to the development of more sensitive intake and treatment systems for culturally unique persons. It is hoped that the results of this study will contribute to a better understanding of African immigrants' experiences involving mental health, mental illness, and help-seeking in the U.S. Chapter 3 includes the rationale for selecting IPA as the research design and will also describe the study's methodology in greater detail.

Chapter 3: Research Method

The purpose of this qualitative research was to explore the lived experience of mental health, mental illness, and help-seeking experiences among African immigrants in the U.S. Chapter 3 contains the introduction, research design and rationale, role of the researcher, methodology, issues of trustworthiness, and a summary.

Research Design and Rationale

Research Questions

RQ1. What is the lived experience of mental health for African immigrants in the U.S.?

RQ2. How does indigenous cultural stigma occur in the meaning of mental illness?

RQ3. How do African immigrants to the U.S. describe their help-seeking experience?

R41. How does indigenous cultural stigma occur in help-seeking?

Central Concepts/Phenomenon of the Study

The primary phenomena of interest were mental health, mental illness, and help-seeking. All phenomena were explored within the context of cultural backgrounds and present immigrant experiences of participants. Experience and meanings involved in mental health, mental illness, and stigma are strongly related to traditional cultural beliefs and practices, and therefore EW different from Western and American cultural beliefs.

Rationale for IPA Design

The phenomenological approach selected for the proposed research was IPA. IPA involves exploring methodically the meaning individuals attach to their lived experiences, which helped me make sense of their private and social world IPA s

premised on three significant philosophical concentrations: phenomenology, hermeneutics, and ideography (Finlay, 2009; Smith et al., 2009; Smith et al., 2013).

Another unique feature of IPA is the "double hermeneutic" perspective on the experience of the participants. Smith et al. (2009) said, "The participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world" (p. 40). According to Smith et al. (2009), it is challenging "to critically and reflectively evaluate how these pre-understandings influence the research" (p. 40). Other phenomenological approaches were reviewed but not selected because IPA most suited to this task.

Role of the Researcher

The role of the researcher as observer, participant, or observer-participant in IPA is to fully understand participants' thorough descriptions of their lived experiences regarding the phenomenon and present the findings using common themes (Patton, 2015; Smith, 2011). I aimed to understand participants' perspectives and meanings they made of their experiences, while asking questions and encouraging participants to examine and reflect over their experiences.). I developed the data collection tools and collected, analyzed, and interpreted data. As such, I recognized that potential biases were present throughout the research process. In IPA studies, the researcher is an active participant during data gathering as well as the analysis and interpretation processes (Patton, 2015, Smith et al., 2011). I implemented double hermeneutic or two-stage interpretation processes that involved participants in the study attempting to make sense of their lived

experiences. I helped participants examine their experiences in ways that guided them toward clarification and understanding.

I share cultural beliefs with participants in terms of their experiences with mental health, help-seeking, and mental illness treatment. I was born and raised in Akwa Ibom State in the South-South Region of Nigeria and West Africa and have traveled widely in Africa, Asia, Europe, the U.S., and Canada. I understood with clarity African immigrants' attitudes regarding American cultural beliefs, language dissimilarities, spirituality, and migration. I came to the U.S. as an international student to study and then became a legalized resident and African immigrant before becoming a U.S. naturalized citizen. Because of life experiences, I understood the challenges regarding acculturating to Western society and difficulties in terms of reconciling fundamental cultural beliefs regarding experience and meaning of mental health, mental illness, and help-seeking. I worked as a behavioral health analyst, mental health counselor, and mental health therapist with different accredited behavioral and mental health organizations, all of which offered mental health services to ethnically diverse minority population groups, including African immigrants. Based on these experiences and expertise, I decided to pursue a Ph.D. in Clinical Psychology and explore African immigrants' experiences regarding mental health, mental illness, and help-seeking in the U.S. To minimize ethical dilemmas, I ensured that there were no existing professional or business relationships between or among prospective participants and myself. I recognized that there was a risk of bias which could arise from shared African ancestry, traditional cultural beliefs,

historical backgrounds, socioeconomic backgrounds, religious convictions, language similarities, and values.

I focused on participants' interpretations of their lived experiences regarding the phenomenon under study. African immigrants have different experiences in terms of mental health, mental illness, and help-seeking trends and patterns. Investigator alleged that understanding African immigrants' experiences concerning mental health, mental illness, and help-seeking conditions, as a distinct ethnically diverse minority immigrant population group in the U.S. would enhance understanding of their problems and how to address them properly as the phenomenon under investigation. Descriptions of lived experiences of African immigrants concerning mental health, mental illness and help-seeking conditions, the phenomenon under study, and information obtained from the literature review would be beneficial to the discipline of psychology science, psychology research community and mental health professionals and researchers, and the mental health policy makers.

The researcher, who was the only investigator in the proposed research, selected the prospective participants for an interview, organized and managed interview sessions, and collected and analyzed data. Through careful effort, the researcher collected unbiased data and made sure that the prospective participants in the research were not friends or known or familiar individuals. The participants were offered ample opportunity to review the summary of their interview transcription to validate that they depicted what they discussed in the interview to establish trustworthiness and accuracy. The researcher explained the purpose of the research, the risks that may be involved, and the

participation benefits to the participants. Additionally, the researcher informed the participants of their right to withdraw from the research at any time, during the data collection and analysis. The researcher also clarified how the participant's confidentiality was protected during and after the research and obtained informed consent from every participant.

Methodology

Participant Selection Logic

Population. The target group for the proposed research was African immigrants who have mental health, mental illness, and help-seeking experience in the U.S. Most African immigrants to the U.S. prefer to live in large metropolitan settings, and most have settled in Washington, DC, New York, Georgia, Texas, Maryland, Virginia, Massachusetts, Pennsylvania, and California (Immigration Policy Center [IPC], 2012). The participants for the study were recruited in Los Angeles, CA, a large metropolitan area with a large African immigrant population that participates in African social, cultural, and religious organizations.

Sampling strategy. A purposeful, homogeneous sample was developed through a combination of referral and snowball sampling of African immigrants with mental health, mental illness, and help-seeking experience (Patton, 2015). Referrals included associates and colleagues of the researcher who had access to individuals meeting the inclusion criteria. An invitation letter was sent by email or distributed in person by asking these referral sources to pass along the invitation (see Appendix A).

Snowball sampling was utilized for the identification and selection of information-rich cases connected to the phenomenon of under study (Patton, 2015). This was a compelling recruitment procedure in which the research participants were requested to help the researcher to identify other prospective respondents who could participate in the research (Patton, 2015). It was an excellent technique for conducting qualitative research with a specific and reasonably small group that could be difficult to find or identify. When the researcher identified two or three African immigrant participants in the research, they were almost certain to know other African immigrants who could participate in the research (Patton, 2015). This technique worked for ethnically diverse minority population where individuals with mental health, mental illness, and help-seeking problems preferred to conceal their problems because of cultural stigma (Patton, 2015). This procedure revealed developments that utilized and established social networking, with the ability to enhance trustworthiness and dependability because the referral sources were able to affirm eligibility of prospective respondents and make possible the eagerness of the respondents to participate in the study with conformity. The process continued until the researcher obtained all the interviews needed or until the contacts had been exhausted (Patton, 2015).

Criteria for selection. IPA researchers chose individual participants on conditions of whether they could be able to provide substantial information concerning the phenomenon under consideration (Smith et al., 2009; Smith, 2011). Researchers affirmed that, in IPA research, the individuals selected to participate in the research represented the phenomenon of interest rather than the population under study (Smith et

al., 2009; Smith, 2011). Therefore, the individuals selected to be interviewed must be able to provide descriptions of lived experiences with the phenomenon under study. Furthermore, all participants were required to be fluent in the English language as stipulated by the inclusion and exclusion criteria of participants in the research. Participants:

- Have migrated from one of the countries in the Five Main Regions of Africa.
- Have migrated to the U.S. as an adult, i.e., at age 21 or older
- Already lived in the U.S. for at least one year and was willing to talk about their lived experiences.
- We're willing to discuss mental illness and barriers that prevent individuals from seeking mental illness treatment.
- We're willing to discuss social and cultural factors, including traditional beliefs, relevant to mental illness and its significance.
- Read and agreed to the guidelines of the study as described in the Statement of Informed Consent (Appendix B).

Participant recruitment. The study was approved by the Walden University Institutional Review Board (IRB). Approval number for this study was 01-04-19-0170177 and expires on December 17, 2020. African immigrant participants were contacted through referrals from different wardens who because of their professional positions, cultural identities, and social connections had comparatively straightforward contact with individuals who conformed to the recruitment criteria of the research. The researcher exploited opportunities for referrals through personal contacts in addition to

snowballing developments that materialized when the distinguished participants convinced other respondents that they deemed met the research recruitment criterion. The research recruitment flyer explained the purpose of the research and encouraged interested parties to directly contact the researcher (see Appendix A).

Respondents who were interested in participating contacted the researcher by email or telephone and were given more information about the research study and a Consent Form (see Appendix B). The interviews took place at a central location, which could be reached easily through public and other means of transportation. The total number of cases preferred, and the trend of the referral and patterns of the referral revelation were guided by the distinguishing of the proposed sample and the recurrence of information (Smith et al., 2009). The researcher scrutinized the need for the experience and meaning of mental health, mental illness, and help-seeking experience and the saturation of data, accelerating or stopping the rapidity as desirable (Smith et al., 2009).

Sample size. The IPA researchers consider a high quality; comprehensive analysis of a small number of cases an appropriate strategy for this type of research (Smith et al., 2009). The qualitative phenomenological researchers contemplate on a small sample size that will reach the expected saturation point, which means that it has provided enough adequate and quality data to support the outcome of the research (Yuksel & Yildirm, 2015). Researchers established that the saturation point is contingent on whether the researcher is looking for large depiction meta-themes or more comprehensive dissimilarity and controlled themes. Furthermore, researchers established that saturation could be reached by completing the first scheduled 12 interviews and even

fewer if the researcher were investigating simpler or meta-themes (Finlay, 2009; Padilla-Diaz, 2015). Based on these concepts, the target sample size for the proposed research is eight to 10 participants. The researcher carefully monitored the richness and depth of the data, during the analysis process to assess the potential for data and thematic saturation of the critical phenomena. One indicator of saturation to be used is to observe when the codes become monotonous before or after the determined number of interviews with the sample, and the demand for multiple-valued viewpoints and saturation of data; accelerating, measured and will be at rapidity as required (Gentles et al., 2015; Suri, 2011).

Instrumentation

Basis for Instrument Development

The semi-structured one-on-one in-depth interview guide was developed by the researcher (see Appendix C). It was grounded in the investigative principle of phenomenology. The IPA customarily involves the use of semi-structured one-to-one interview procedures to attain narratives, reflections, thoughts, and reactions from the research participants (Smith et al., 2009). This method was used in the proposed research to obtain African immigrants' lived experiences with mental health, mental illness and help-seeking trends and patterns; the meaning of mental health, mental illness, and help-seeking experience with the phenomenon under study (Smith et al., 2009). African immigrants were the investigational experts who provided descriptions of their lived experience with mental health, mental illness, and the help-seeking trends and patterns in the proposed research. Therefore, the interview questions were designed to be open-

ended (Smith et al., 2009). The analytical guide was flexible, and the participants were able to communicate their concerns and insights that may be predictable and unpredictable. The methodology and content experts on the researcher's committee assessed research questions, sub-questions, and interview questions for feedback on the language, tone, and wording. The interview guide was also reviewed by methodological experts to improve the credibility of the proposed instrument.

The proposed interview questions were formulated from published literature reviewed in Chapter 2 that identified the following key content areas as relevant to answering the research question. These key concepts were used to formulate each of the questions. While content validity cannot be formally established, the researcher made substantive efforts to justify the choice and focus of questions based on the literature and theoretical frameworks described in Chapter 2. In Chapter 5, the results based on these questions will be interpreted in the light of these published studies in order to enhance credibility and content validity (Shenton, 2004).

Table 1

Sources for Developing Interview Questions for Content Validity

Key Content Area	**Article Source**
Experience in mental health	(Bagsgasra & Mackinem, 2014; Ciftci, 2013; Fleischmann & Verkuyten, 2015; Gureje & Stein, 2012).
Experience of mental illness	(Akresh, et al., 2016; Glied & Frank, 2016; Parcesepe & Cabassa, 2013).

Meaning of help-seeking experience	(Amri & Bemak, 2013; Derr; 2017).
The occurrence of indigenous stigma in mental health	(Clement et al., 2014; Douglas & Wildavsky, 1982; Lindinger-Sternart, 2015; Renner & Salem, 2014).
The occurrence of indigenous stigma in mental illness	(Abdullah & Brown, 2011; Dale & Daniel, 2013; Schock-Giordano, 2013).
The occurrence of indigenous stigma in the help-seeking experience	(Aina & Morakinyo, 2011; Akomolafe, 2013; Leong & Kalibatseva, 2011; Schock-Giordano, 2013).

Procedures for Recruitment, Participation, and Data Collection

The researcher started preliminary inquiries through the relaxed verbal presentation to describe the purpose of the research and recruitment process. A flyer about the study was distributed (see Appendix A). Certain individuals distributed the flyer, and those responding to the flyer by email was sent and asked to return a fully signed consent form (see Appendix B). Once the consent form was received, the first interview was scheduled. The plan was to complete eight to 10 interviews. However, if the recruitment process fell shortly after the initial effort, then the researcher was to re-contact colleagues and other referral sources and re-distribute the invitation letter by email or distributed in person to another group of individuals (see Appendix A).

All participants in the proposed research were interviewed in English, using the semi-structured interview guide (see Appendix C). The researcher reserved a private,

quiet room in the community center. The researcher created a calm and comfortable environment for every interviewee. The setting had appropriate furnishings, including arrangement of chairs to enhance face-to-face interviewing techniques, as well as ensure that the audio-recording system was working correctly. Water was provided for the interviewees. The researcher reviewed the objective and the nature of the proposed research, reminded the participants concerning their agreement to participate, addressed the participants' concerns and answered all the questions that arose concerning the proposed research. Furthermore, the researcher explained the compositions of the interviews, the procedures of the interviews, and the probing questions determined by the participants' information concerning the phenomenon under study.

The researcher reminded the participants of their right to decline to participate and right to withdraw and leave the study at any time once the interview began. The researcher also informed the participants of ethical protection and confidentiality before the beginning of every interview. All the interviews were individually conducted to collect data for this proposed research study, and the approximate length of time for each interview was 45 minutes to 1 hour. After the interview, each participant was debriefed, which included a brief reiteration of confidentiality and a description of future contact for the member checking process.

The audio-recorded interviews were given to a recognized and approved data transcription agency for transcription. The researcher released no personal information concerning the participants to the transcription agency. The transcription agency signed the mandatory Transcriptionist Confidentiality Agreement in (see Appendix F). After

transcription, the agency presented three categories of interview audio-recording, including (1) the original interview audio-recording, (2) an electronically transcribed interview audio-recording, and (3) the hard-copy of the interview audio-recording. The researcher summarized each interview transcript by question and sent the summary to each participant for member checking and feedback. The procedure offered the participants ample opportunities to review their experiences and add, change, or delete content. This technique improved the trustworthiness of qualitative analysis (Carlson, 2010; Koelsch, 2013; Smith & Noble, 2014).

Data Analysis Plan

The following research questions guided the study:

RQ1: What are lived experiences involving mental health for African immigrants in the U.S.?

RQ2: How does indigenous cultural stigma occur in terms of mental illness?

RQ3: How do African immigrants in the U.S. describe their help-seeking experiences?

RQ4: How does indigenous cultural stigma occur in help-seeking?

Interview guide question #4 inquired individually about the lived experience of mental health (RQ1). Interview guide questions #2 and #3 inquired into the experience of stigma in identifying and seeking help for mental illness in the U.S. and the country of origin (RQ2). Interview guide questions #1 and #5 inquired concerning experiences with American Mental Health System (RQ3). Interview guide question #4 inquired about the description of what mental health means in the U.S. (RQ4).

The IPA approach necessitates that the transcripts of all audio-recorded interviews must explain all the expressions communicated by the interviewees and comments explaining non-verbal declarations like mirth, a significant break in proceedings, and indecisions (Smith et al., 2009). The researcher assigned a code to each transcript to protect the participant's privacy.

The audio recording was reviewed, and the verbatim transcripts carefully read through for sometimes as appropriate to have clarity for easy understanding and interpretation of the interview data. The researcher took notes in the areas of expounding, conceptual interpretation, and exact synonyms. The expounding notes focused on interview content. Conceptual explanation notes focused on interpretative and integrated searching of data for more substantial ideas and use of exact synonyms specifically considered the communicative abilities of the participants (Smith et al., 2009). The developing themes among individuals were first determined among individual participant's case before the classified patterns (category with a system of classification) and themes that join the developing themes (Smith et al., 2009). The rate of recurrence that the developing theme appears in the transcripts was noted as a sign of its relative significance to the participant (Smith et al., 2009). The perspective and meaning of the developing themes were considered in following educational and explanation components (Smith et al., 2009). The researcher thoroughly investigated the action of combating connections. The perception was that knowing the meaning of mental health, mental illness, and self-seeking experience among African immigrants may offer a better understanding of the problem (Smith et al., 2009).

After the analysis of individual cases, the focus was changed to evaluating the group relationship and recurring themes which may be relevant to a more significant part of participants. The group themes were determined and confirmed by identifying their rapidity of recurrence among the cases and were shown through paradigms taken from individuals (Smith et al., 2009). The researcher explored the discrepant cases and responses to determine for their particular significance, which may enhance the understanding of the meaning of mental health, mental illness, help-seeking with indigenous cultural stigma in the meaning of mental illness and help-seeking among African immigrants to the U.S. The researcher used NVivo, a qualitative data analysis (QDA) software program for management and storage of data (Hamed et al., 2013). The QDA enhanced data management by organizing several clustered data categorizers, organizing impressions generated in the study, and reporting the clinical findings based on the transcript information (Halim et al., 2013).

Issues of Trustworthiness

Trustworthiness involves the degree of confidence that the qualitative research maintains, which may be compared to the quantitative terminologies of reliability, objectivity, and validity (Denzin & Lincoln, 2012; Marshall & Rossman, 2015). Universally, the qualitative and quantitative researchers utilize comprehensive empirical techniques designed to confirm the trustworthiness of their clinical findings (Patton, 2015). The trustworthiness in qualitative research is measured according to the four established criteria of credibility, transferability, dependability, and confirmability (Patton, 2015; Smith et al., 2009).

Credibility

Credibility is a trustworthiness criterion that is comparable to internal validity in qualitative research (Denzin & Lincoln, 2012; Marshall & Rossman, 2015). Credibility requires establishing that the findings of qualitative research are trustworthy from the perspective of the research participants. Credibility was determined through prolonged engagement with the participants during data collection. The researcher immersed himself in the participants' world to gain insight into the context of the research. The researcher decreased distorting information which may have transpired during interviews. The researcher's prolonged time with the participants to conduct multiple interviews enhanced confidence. Spending enough time with the participants enabled the researcher to understand the main issues that may influence data quality and enhance trust with the study participants.

The researcher also employed member checking of interview transcript summaries to verify that the researcher's interpretation of the interview key points aligns with the participants' intents (Denzin& Lincoln, 2012; Marshall & Rossman, 2015). Peer debriefing technique in the proposed research involved getting feedback from methodology expert and content expert who were the researcher's reviewers to assess research findings. Peers may address issues of bias, mistakes of actuality, challenging explanations, and/or increasing differences involving data and the phenomenon and materialization of themes; all of which comprise of a prolonged but essential technique for establishing credibility (Denzein & Lincoln, 2012; Marshall & Rossman, 2015). The researcher requested support from other professionals who were willing to offer scholarly

guidance. The researcher sought peer-review subject matter experts and methodologists on the review of research questions and the interview guide (Denzin & Lincoln, 2012; Marshall & Rossman, 2015).

Transferability

Transferability refers to the extent to which the reader may transfer the research findings to meaningful contexts and individuals (Shenton, 2006). The researcher provided a thoroughly defined explanation of the procedures through the data gathering process and analysis process (Denzin & Lincoln, 2012; Marshall & Rossman, 2015). The researcher described the settings, research design, and methodology and provided the participants with a complete explanation for the information to be transferable to other groups and contexts. The researcher accomplished transferability, using rich description and another technique for establishing credibility in qualitative research.

Dependability

Dependability ensures that the research findings are dependable and may be repeated (Denzin & Lincoln, 2012; Marshall & Rossman, 2015). Dependability is considered the standards under which the research is executed, analyzed, and presented. This process also facilitates the researcher's ability to understand the methodologies and their usefulness.

Confirmability

Confirmability in qualitative research is comparable to objectivity in quantitative research and relates to the degree that the clinical findings transpire from the participants' perspectives and lived-experiences, not the researcher's preferences and characteristics,

and is supported by the data collected and analyzed by the researcher (Denzin & Lincoln, 2012; Marshall & Rossman, 2015; Patton, 2015). The qualitative researcher can establish confirmability by presenting a clear audit trail that encompasses raw data, documentation of course of actions, accurate analysis, and routine reflexive individual annotations (Marshall & Rossman, 2015; Patton, 2015). Data was organized consecutively to make it possible for others to understand the research course of action. The researcher's audit trail was comprised of preliminary annotations on research questions, suggestions, sampling selection process, interview schedules, audio recordings, word for word transcriptions, memorandums, theme-tables, paradigms, draft- reports, and the concluding report. Fundamentally, researchers must understand the epoch process, understanding their inclinations, prejudices, perspectives, and assumptions (Marshall & Rossman, 2015; Patton, 2015; Shenton, 2004). The epoch process is an enduring problem-solving procedure that allows the researcher to be exposed to innovative insights and mutual comprehensions (Marshall & Rossman, 2015; Patton, 2015).

The researcher was involved in the epoch process and worked to manage personal biases, prejudices, presumptions, and presumed meanings so that research data was collected, analyzed, and interpreted on its possible terms. Conformability was established by making available the supportive research information that enabled others to authenticate the research interpretations and arguments (Marshall & Rossman, 2015; Patton, 2015). The researcher utilized a significant quantity of word-for-word quotations from every participant and not only a few that were offered to authenticate the research

interpretations and clinical conclusions. The interpretations and conclusions are relevant to the literature review analysis. Expressly, the IPA authorizes the possibility of utilizing a measure of justifiable descriptions so that the problem can be addressed by generating a logical and apparent description of the research data (Smith et al., 2009; Smith, 2011). The intra- and intercoder reliability (where applicable) were not used in this research.

Ethical Procedures

The researcher sought and obtained approval, before collecting any of the data from the Walden University Institutional Review Board (IRB). Approval Number for this study was 01-04-19-0110147 and expires on December 17, 2020**.** Approval guaranteed that the research met the required guidelines for an institution-supported research project, including ethical guidelines. The participants in the research participated voluntarily, without compensation, and were recruited separately from the researcher's employment, professional and social circles. The study had no known dangerous conditions that may affect their safety and security. However, the subject matter was construed as personally sensitive. Therefore, to respect potential ethical challenges in the conduct of this study, the researcher made every effort to address the participants' concerns, offered participants debriefing information before registering of interest in the study, and thoroughly communicated the expectations of the study to all participants. Also, the researcher reminded participants at several stages of the interview that if interview questions provoked distress, they may discontinue at any point without penalty, and they would be supplied with mental health resources on which to call (see Appendix D).

The proposed research was conducted in conformity with the information storage and safety procedures (5 years in locked and password protected files), as established in the Walden University Institutional Review Board application. Every participant in the proposed research was presented with a Consent and Security Form in to read and complete, after establishing individual eligibility for participation (see Appendix B). The researcher also maintained a chronological research journal with participants' contact information, notes for specific purposes, summarized concerns, follow-up issues, and other relevant information.

This journal, along with all the study files, organized computer data, audio tapes, and transcripts relevant to the proposed research, was stored in a locked security safe cabinet located at the researcher's home office. Only the researcher had access to the data. A secure password protected all electronic files related to the proposed research study. Additionally, the researcher will maintain the raw data files for five consecutive years before removing them permanently from the computer system and shredding the paper documentation. Each participant was assigned a pseudonym for the study, to ensure his/her safety and confidentiality. The researcher eliminated identifying information from the transcripts after information verification.

Before the research began, the participants were given detailed information concerning the dangers and threats, time constraints, benefits, and potential follow-ups involved in the proposed research. They were also given information on available local community mental health care services and treatment centers, in case participating in the study caused them stress. The participants were informed that the published research will

not include any of their individual recognizable information, that any information they supply will remain confidential, and that it will not be communicated to any person except the members of the researcher's dissertation committee and the Walden University IRB. Finally, the participants were guaranteed that no danger or exposure to harm would occur because of their participation in the proposed research.

Summary

This chapter introduced an IPA study that explored African immigrants' experience of mental health; mental illness and help-seeking in the U.S. Segmented assimilation theory and the cultural theory of risk were utilized as a theoretical framework for the study. A purposeful, homogeneous sample was developed through a combination of referral and snowball sampling of African immigrants with mental health, mental illness and help-seeking experience. Data was analyzed for the consistent experience of mental health, mental illness and help-seeking themes and patterns that contributed to an improved understanding of the procedure. Additionally, it presented and defended the chosen theoretical framework and explained how the study would be conducted. Specific topics included participant selection, interview techniques, data collection techniques, and methods for organizing and analyzing the data. The data resulting from this study was used to determine African immigrants' experience of mental health, mental illness and help-seeking in the U.S. Chapter 4 will describe the results of the research in detail as well as demographics, data collection and data analysis, and trustworthiness evidence.

Chapter 4: Results

In this phenomenological study, I explored the experiences of nine African immigrants who migrated to the U.S. from countries within the five main regions of Africa regarding mental health, mental illness, and help-seeking. There were four research questions:

RQ1: What is the lived experience of mental health for African immigrants in the U.S.?

RQ2: How does indigenous cultural stigma occur in the meaning of mental illness?

RQ3: How do African immigrants in the U.S. describe their help-seeking experiences?

RQ4: How does indigenous cultural stigma occur in help-seeking?

I used IPA as the approach to define the sample, develop interview guide questions, and analyze data. This chapter includes descriptions of the research setting, demographics, data collection, data analysis, and evidence of trustworthiness, results, and a summary.

Setting

I conducted interviews from February 17, 2019 through April 18, 2019. Interviews were conducted at times and places selected by and convenient to the participants. Two interviews were conducted in participants' homes with their approval; seven interviews were conducted through the telephone as requested and approved by participants. No significant deviations from planned primary procedures were encountered or experienced.

Demographics

Seven participants were male and two were female. Participants' ages ranged from 41 to 68. All but two of the participants completed higher professional education in their respective areas of learning. All participants migrated from African countries to the U.S. and were living in the U.S. at the time of the interview. All participants were fluent in English, and interviews were conducted in English. Table 2 includes a summary of participant demographics and characteristics. In one case, the participant referred to two individuals, male and female. Only one participant referred to him or herself in terms of relating the experience of the phenomena: the rest referenced family, friends, and work-related relationships. Also, persons who used patients as examples referred to only those individuals who they observed but had no direct patient care interactions or responsibilities.

Table 2

Summary of Participants' Characteristics

Code	Gender of Participant	Age	Occupation	Gender of the Person Seeking MH Services	Relationship to the Person Who Was Interviewed	Help-Seeking Condition
P1	Male	57	Caregiver	Male	Patient	Mental Health
P2	Male	60	Community Development Consultant	Female	Family Friend	Mental Illness

P3	Female	57	Medical Practitioner	Female	Patient	Mental Illness
P4	Female	60	Medical Social Worker	Male	Family Friend	Mental Health
P5	Male	60	Health Care	Male	Family Friend	Mental Illness
P6	Male	68	Health/Human Services Consultant	Female	Family Member	Mental Illness
P7	Male	41	Professional Counselor	Male	Self (reported on experience)	Mental Health
P8	Male	62	Mental Health Clinician	Male	Family Friend	Mental Illness
P9	Male	41	Professional	Male	Roommate	Mental Illness

Summary of Participants' Experiences

P1. The first interviewee was a 57-years old man identified as an African immigrant. He migrated from his native African country to the U.S. more than 10 years ago. He works at a local community health facility as a Care Manager. He described his experiences with two individuals, a man and a woman diagnosed with mental health disorders and mental illnesses. The male individual was diagnosed with Alzheimer's disorder, and the female individual was diagnosed with postpartum depression, and both were patients at the local community health facility. However, he had no direct involvement with their care. P1 emphasized that his academic preparation and professional experience enabled him to understand with clarity the entrenched challenges

and complications involved with these two medical conditions. He described his understanding of the perceived contributory factors of mental health disorders and mental illness, and there was a significant need for help-seeking. He described the notion of mental health in his native African country as distinctly different from the construct of mental health in the U.S., including modalities of treatment based on traditional cultural beliefs and family involvement during the treatment process and recovery. Furthermore, in the U.S., there was no family support and this creates difficulties and challenges.

P2. The second interviewee was a 60-year-old man who migrated from his native African country to the U.S. more than 10 years ago. He is a professional community development consultant who described mental health as a neglected medical condition among African immigrants that is directly linked to other physical conditions. He emphasized that mental health was the foundation for emotions, communications, thinking, resilience, attentiveness, self-esteem, better relationships, individual wellbeing, and career advancement. P2 asserted that through mental health, African immigrants could be exposed to other medical conditions that require medication treatment, but mental illness was complicated due to his cultural beliefs. He worked with individuals who were coming out of transition and reentry social programs. P2 described being called one day by a family friend who told him that her daughter was throwing things carelessly all over the place and becoming dangerous to herself and other family members. P2 witnessed that the girl was transported to a community medical center, and from there, she was referred to a psychiatric hospital where she was diagnosed and treated for mental illness.

P3. The third interviewee was a 57-year-old woman who migrated from her native African country to the U.S. more than 10 years ago. She said that she was a medical practitioner and worked at a community health center that provides primary care and mental health services to the general public, including African immigrants. P3 emphasized that her academic preparation and professional experience enabled her to understand embedded challenges of mental health, mental illness, and help-seeking among ethnically diverse minority immigrant population groups. Furthermore, she described how depressed individuals come to the community health center for physical and psychological assessment before established diagnosis and treatment for mental illness. She mentioned that some patients are considered for referral and others are handled through in-patient care and out-patient care services. P3 described her understanding of the U.S. mental health system, mental health services offered, and disparity issues in terms of services offered to ethnically diverse minority immigrant population groups. P3 described her personal understanding of challenges caused by African immigrants' traditional cultural beliefs that hindered their ability to submit themselves to be assisted or being helped by medical professionals. Significant challenges for medical care professionals and mental health treatment teams were not talking about mental health issues, not being willing to take medication or believing in prayer to get well.

P4. The fourth interviewee was a 60-year-old woman identified as an African immigrant. She migrated from her native African country to the U.S. more than 10 years ago. She said she is a medical social worker and works for a local school district. P4

emphasized that her academic training and professional experience enabled her to understand the challenges of mental health among African immigrants, with social and economic challenges they face in the U.S. P4 described her experience with a family friend who was not able to do anything to help himself but claimed to be depressed all the time, and understanding that depression is linked with mental health issues, decided to help the person to seek help for his problems. P4 reported that the person was taken to the community mental health clinic, where he was diagnosed and treated for mental health disorders, but medical insurance and cultural beliefs were significant challenges to the mental health clinicians.

P5. The fifth interviewee was a 60-year-old man identified as African immigrant. He migrated from his native African country to the U.S. more than 10 years ago. He said he works as a health care management consultant for a local medical group. P4 emphasized that being an African enabled him to understand that African cultures stigmatize individuals with mental health issues and their families, and African immigrants to the U.S. should not be exempted. P5 stated that, because of stigma, mental health-related issues are not openly discussed outside the family in African cultures. P5 emphasized that, mental health problems could extend to include emotional instabilities, because as an African immigrant to this country sometimes economic challenges and pressures that you face could cause you to develop certain medical conditions that you never experienced, also, maybe your family members of your native African country never experienced. P5 described that his understanding of the American mental health system offered clarity for knowing available resources for individuals with mental health

problems, and also described his experience with a family friend who reported to me that he was having severe problems and did not know what to do or how to seek help for his problems. P5 asserted that, he told him to go to his primary doctor, and from there, he was referred to a mental health treatment center for further psychological evaluation and treatment. Finally, P5 confirmed that his friend was diagnosed with mental health disorder and placed on psychotherapy and medication therapy, and the mental health clinicians were able to help him despite cultural and language dissimilarities.

P6. The sixth interviewee is a 68-year-old man identified as African immigrant. He migrated from his native African country to the U.S. more than 10 years ago. He is a professional health and human services consultant in private practice with many years of experience. P6 emphasized his academic preparation and professional experience enabled him to understand that, mental health problem as the sickness of the mind, which individuals could not comprehend what is happening to them, preferably in the way healthy individuals do as they go about completing their daily functional responsibilities. P6 described his experience of mental health issues with a family member who was seeing things that others could not physically see, received and greeted imaginary guests that were not there, became frightened when not threatened, exaggerated un-realistic things, over thinking about conditions that were not threatening to other people. P6 reported that he recognized the condition as an imbalance of position of things but were appropriate usually to other family members but seemed not the same together when measured. P6 also described the experience with his niece who was taken to the hospital to be seen by the primary doctor, after an evaluation, established that her problem was a

mental health problem; she was referred to a psychiatric hospital for further evaluation, diagnosis, and treatment.

P7. The seventh interviewee is a 41-year-old man identified as African immigrant. He migrated from his native African country to the U.S. more than 10 years ago. He works as professional counselor for a local counseling services organization. Described his experience of contacting the local department of justice, law enforcement agency, and the American mental health system because of his mental health problem. P7 emphasized that, the contributory factor of my mental health problem was being that, at the graduate school, he became friendly with a lady that he met, and who did not inform me that she had a boyfriend. P7 reported that, later on, in the same year, she told him that she had a boyfriend and was engaged to the boyfriend, and the problem he had was trying to separate himself from the relationship he had with her because now she was engaged, and he was no longer the boyfriend. P7 asserted that this was a mental health problem from the standpoint that he had to detach from the relationship with somebody that was very close to him and being forced to detach myself with no exceptions. P7 reported that, there was a court order that he could no longer contact the lady because she was engaged to be married to somebody else; and was more of a case for him having to find a way to live without this lady in his life and to find a new friend. Finally, P7 asserted that, this led to being evaluated and diagnosed with an established mental health disorder and treated for this disorder with psychotherapy counseling sessions that were effective for my problem.

P8. The eighth interviewee is a 62-year-old man identified as an African immigrant. He migrated from his native African country to the U.S. more than 10 years ago. He works as a mental health clinician at the community mental health treatment center, with many years of experience working with ethnically diverse minority immigrant population groups, including African immigrants. P8 emphasized that his academic preparation and professional experience enabled him to understand that most individuals who are diagnosed with mental illness do not want to talk about it, but mental illness was nothing to be ashamed of; it is a medical condition just like heart disease or diabetes. P8 stated that, mental health conditions are treatable and are unremittingly expanding human understanding of how the human brain works, and treatments are available to help people successfully manage their mental health conditions. P8 described his experience with a family friend who was no longer able to go to work, and was no longer able to function and take care of himself; he stayed at home and would not want to go out but told the members of his family to close all the windows because he figured out that people were using cameras to trace where he was so that they can arrest him and lock him up without evidence of committing any crime. P8 reported that, his friend was frightened with nothing to substantiate that people were following him and stopped going to work because he assumed people were trying to arrest him. He lost appetite for food and nutrient. He complained of hearing voices and seeing people pursued him with other individuals experiencing what he complained about at present. P8 asserted that, he took his friend to the community mental health treatment center, and he was evaluated and

diagnosed with mental illness and admitted for in-hospital treatment in a locked psychiatric unit.

P9. The ninth interviewee is a 41-year-old man identified as an African immigrant. He migrated from his native African country to the U.S. more than 10 years ago. He works as a professional counselor for a counseling organization. P9 described his experience of mental health, mental illness, and help-seeking with an understanding of the American mental health system. P9 emphasized that his academic preparation and professional experience enabled him to understand that American mental health system leaned to the concept that, African immigrants do not understand American mental health care systems because they are not familiar with how mental health treatment which provided in the U.S. measured up to the mental health treatments provided in their native African countries. P9 described experience with his college roommate that was diagnosed with bipolar disorder and given treatment that was effective.

Data Collection

Snowball sampling was used to collect data from the nine participants in the study. Referrals came from different community and professional sources that included community leaders, community churches, family members, medical professionals, mental health care providers' professionals, and psychologists who worked in clinical settings and policy-making organs with ethnically diverse minority immigrant population groups. Data collection started on February 17, 2019, through May 17, 2019. Participants were selected to participate in the study if they were African immigrants' aged 21 years old

and older, who migrated to the U.S as adults and have lived continuously in the U.S for a minimum of one year to the date of the study and could communicate in English.

The participants were interviewed either over the telephone or face to face. All interviews lasted between 45 and 60 minutes, and the researcher took detailed notes during the interview process. All interviews either by telephone or face to face were audio-recorded by Sony digital stereo voice recorder. All the interviews were then transcribed through Transcription Puppy transcription service. Transcriptions were edited for accuracy while listening to the audio recording. Summaries were created based on the content and these were sent to all participants for voluntary member checking for accuracy, trustworthiness, and evaluation. Participants were advised to inform the researcher of any misinterpretation and inaccuracies, as well as any additional information they wanted to discuss. All the participants reviewed their interview summaries and validated the summary's data accuracy and trustworthiness. No participant offered to correct discrepancies in descriptive data, and no participant offered additional lived experience description of mental health, mental illness, and help-seeking.

Data Analysis

Procedures

The IPA approach includes six steps for data analysis including "reading and re-reading, initial noting, developing emergent themes, searching for connections across emergent themes, moving to the next case, and looking for patterns across cases" Smith et al., 2012, p.81). These six-steps were utilized in this study as a guide to the thematic analysis. The researcher began with a single transcript so that major thematic elements

could be identified. The researcher submerged himself in the original transcript to ensure that the participant is the focus of the research.

This procedure slowed down the tendency of swift reduction and summation of data, so the researcher was able to spend substantive and thoughtful time, note-taking and reflecting during this initial stage. The researcher did this for the first three transcripts, noting similar and unique thematic elements that could be organized into key content areas. Then, as the researcher read and summarized each interview, he sought out where similarities and dissimilarities occurred. By the time he had reached the 6th interview, no new themes were emerging, and he continued to summarize the rest of the interviews. The results of the process are described below.

First Cycle

After carrying out the above procedures, the researcher organized the results of the analysis using the key content areas associated with the interview questions, and then related the dimensions identified from the transcripts to each of the content areas. The figure representing the key content areas is below, followed by the table of dimensions associated with the content areas (see Figure 1). The key content areas were identified in Table 1, Chapter 3, and were formed from the substantive areas identified in the research reviewed in Chapter 1. I noted that while most of the transcript results fell within the originally identified areas, further distinctions were made to reflect common experiences that were distinct from or resulting from the original identified areas. The new key content areas include the experience of prejudice and discrimination in mental health, the experience of the patient, and the utilization of U.S. These are discussed in detail in the

results section, along with accompanying quotes from transcripts to illustrate the meaning of each content area.

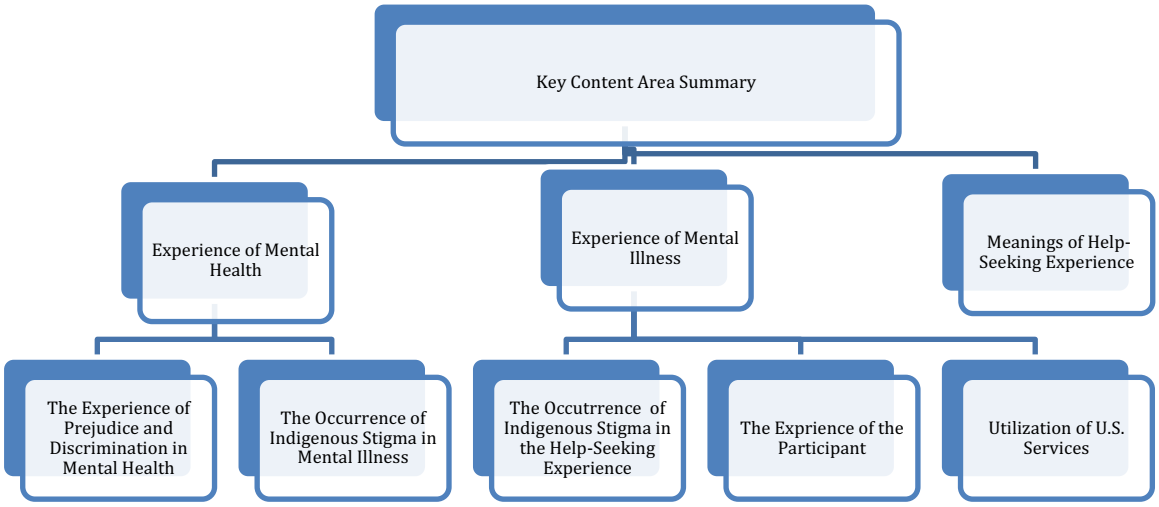

Figure 1. Arrangement of the key content areas.

Second Cycle

The second cycle approach involved going back to the details of the transcripts, identifying unique codes within and across cases. A codebook was created to organize and keep track of the codes. The code book contained the chronological descriptions of the codes present in the analyzed interview data and supporting expressions. The codebook enhanced the researcher's abilities to remain focused on data analysis and gain clarified insight for better understanding of the participants' lived experience. By reading and re-reading the detailed codes within each theme, the researcher was able to create eight broad categories. The codes associated with each category are included in Appendix G. This is shown in Figure 2, listing the eight categories that occurred in chronological

order. These are also discussed in detail in the results section, along with accompanying quotes from transcripts to illustrate the meaning of each content area.

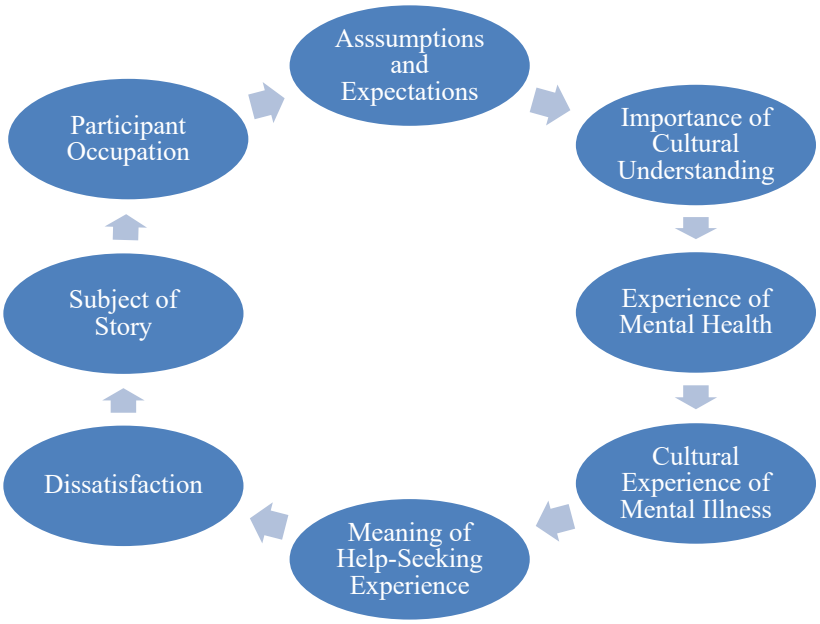

Figure 2. Arrangement of merged categories.

Evidence of Trustworthiness

The trustworthiness in qualitative research was measured according to the four established criteria of credibility, transferability, dependability, and confirmability.

Credibility

The SAT and CRT were used to establish the credibility of the study to guide the development of the interview and guide the interpretation of the results. IPA was used to guide the analysis process, and this is a well-established qualitative methodology. Member checking contributed to credibility because the participants were given ample opportunity to review their interview transcription summaries of the key content areas.

Peer feedback was obtained from reviews of the interview guide by methodology and content experts.

Transferability

Transferability is the extent to which the reader could transfer the research findings to meaningful contexts and individuals (Shenton, 2006). This study thoroughly defined the procedures (data collection process, data analysis process), and the participants sufficiently to be transferable to other groups and contexts. The study ensured the lived experience descriptions of the participants were detailed enough to support the development of the theoretical explanation and the study analyses of the data. I strived to obtain rich, descriptions for transferability.

Dependability

Dependability is concerned with ensuring that the research findings are dependable and can be repeated (Denzein & Lincoln, 2012; Marshall & Rossman, 2015). All participants were asked the same questions via the Interview Guide, although not necessarily in the same order (see Appendix C). Transcripts of the audio recordings of participants' interview responses were summarized and member checked. Research data, together with interview transcriptions, summaries, researcher notes, and audio recordings, were safely stored to enable replication of the study.

Gatekeepers who were familiar with the experience and history of the selected participants referred the participants in this study. This process helped to enhance the dependability of the study as referral sources were well-informed to verify the eligibility of prospective participants and make possible their willingness to speak truthfully.

Confirmability

All interviews were recorded and transcribed verbatim. Audit trails were employed throughout the data collection and analysis process. Follow up questioning was utilized for clarity of participant's answers and to explore for better understanding. For the analyses, I employed a two-cycle coding method, and identified consistencies across cases, and word for word quotations were utilized. I continually moved back to the original recordings and transcripts to confirm that the meaning of the original data was kept intact.

Results: First Cycle

Table 3 summarizes the results of the First Cycle, using the Key Content Areas connected with the Interview Guide Questions, and the resulting dimensions. Each content area is briefly defined, followed by a discussion of dimensions with quotes from the transcripts.

Table 3

First Cycle

Key Content Area	Thematic Analysis Dimensions
Experience of Mental Health	• Unique Conception of Mental Health • Family/Community Connection • Utilization of Services • Believes in Traditional Approaches of Healing
Experience of Mental Illness	• Unique Conceptions of Mental Illness • Challenging Life Issues • Cultural Judgments • Barriers to Seeking treatment

(Table continues)

Key Content Area	Thematic Analysis Dimensions
Meaning of Help-Seeking Experience	• African Experience • Traditional Methods of Treatment • U.S. Experience • Cultural Influences • Utilization of Services • Barriers and Implications
The Experience of Prejudice and Discrimination in Mental Health	• Sensitivity and Discrimination • Assessment and Diagnosis Issues
The Occurrence of Indigenous Stigma in Mental Illness	• Stigma and Culture • Shame and Disgrace • Attitudes Towards Treatment • Social Cost of Stigma
The Occurrence of Indigenous Stigma in Help-Seeking Experience	• Ordeals for Family Members • Barriers to Help-Seeking • Misunderstanding of Help-Seeking
The Experience of the Participant	• Mental Health Problems and Treatment • American Mental Health System • Social and Economic Issues
Utilization of United States Services	• Racial and Ethnic Differences • Mental Health Professionals • Cultural Exclusions and Inclusions • Effectiveness and Acceptability Issues

Experience of Mental Health

The data revealed that this theme had several dimensions. Each of these is identified and described with support from the participants' descriptions of experience and responses. Overall, these dimensions reveal that participants have a unique conceptualization of mental health that goes beyond the superficial differences between the U.S. and the participants' native country.

Unique conceptions of mental health. This dimension is best characterized by seeing with evident African immigrants' conception of mental health as embedded in the physical wellbeing, social background, and understanding of the cultural belief systems and cultural way of life. All participants described their experiences and offered the following responses.

P1 stated:

The mental health issue in my native country is distinctively different from the construct of mental health in the United States.

Most participants described mental health as more holistic.

P5 said:

> Mental health is a state of physical, well-being through which as an individual, I can recognize my own capabilities, can cope with my normal stressors of life, can work effectively and successfully and be able to make meaningful contributions to African immigrants' community.

The family/community connection. The significances of family and community support were noted to be vital to all individuals with mental health issues. P6 stated:

> Africans and African immigrants' cultural belief systems and values of collective support give dignity to individuals regardless of their level in life. In many of the different languages from the continent of Africa, there is no word for being alone. Africans collective approach to human behavior emphasized collective responsibility, shared concern, and commitment to a common cause, and family that is a community center for better.

Beliefs in traditional approaches of healing. Most participants identified traditional mental illness treatments as the mainstay and long-established curative practices.

P1 said:

> African cultures utilize the traditional and culturally accessible methods of treatment provided by native African doctors and faith and spiritual healers. Westernized conception of mental health problem is not accepted in native African cultures; the general population commonly utilizes traditional approaches of healing and culturally approved modalities of local treatment.

Experience of Mental Illness

Mental illness was also conceptualized in ways that were substantively different than the U.S. system. Participants rooted their unique conceptualizations in their native country as well as the immigration paths that lead them to the U.S.

Unique conceptions of mental illness. This dimension is best characterized by seeing African cultures and African immigrants not believing in American conceptualization that mental illnesses are medical problems or health conditions. Some

participants distinguished between their cultural identity (coming voluntarily from Nigeria in contemporary times) and the cultural identity African Americans (Black Americans). P5 said:

> While there are individuals of African ancestry in the U.S. whose families have lived in African community settings in the U.S. for over one hundred years, there is a significant need to understand that their ancestors did not willingly come to the shores of this country.

Second, participants noted that mental illness is not readily discussed. P5 stated, "In my native African culture, mental illness is prohibited from being addressed openly in all circumstances."

P9 said:

> African cultures believe that mental illness and individual disaster are brought on by the discord of wrongdoing such as lack of faith in their god; a person being possessed by angry spirits and even accidents are believed to be under divine control of occurrence.

Challenging life issues. Challenging life issues (demanding physical and psychosomatic undertaking of a challenging category, resembling postpartum depression) among African immigrants were recognized as connected to mental illness.

P1 described the complicated life problems like post-partum depression that aggravate mental illness among African immigrants to the U.S.,

> "Depressed and traumatic condition that occurred after child delivery among African immigrants new mom without appropriate partner's help, family support,

> money issues, problems with alcohol and drugs, and other massive sources of stress, going through depression due to poor economic impediments and lack of accessibility to needed relief resources."

P7 addressed the culturally related challenging life issues relevant with mental illness, stating:

> African immigrants faced a difficult life in the United States, daily stressors wear on their strength and their mentality. Anxiety and mood problems carried a significant individual and collective encumber among African immigrants. The chronological prevalence of mood and anxiety problems among African immigrants could not be addressed appropriately when considered through the conception of traditional cultural belief systems. Mental illness symptoms affected emotions, thoughts, and behaviors among African immigrants; these symptoms generated confused pattern of thinking, reduced abilities to concentrate, withdrawal from families, friends, and society, and inability to cope with daily stress and demands of individual daily life.

Cultural judgments. The identification and expression of mental illness was clearly subject was to cultural influence on judgments in terms of negative behaviors, which were nonconforming with the cultural values. Participants described their major experience and offered responses. P4 stated that, "The contributing factors of mental illness in native African culture are different from the Western conceptualized mental illness; individuals with mental illness are labeled as socially undesirable." P7 said, "The mental health clinicians and researchers represent the White popular class orientation

with their cultural beliefs, values, biases, misconceptions and stereotyping of African immigrants and other ethnically diverse minority population groups."

P5 brought up the issue of how mental health problems influence family and marriage. P5 said, "Mental illness is viewed as a very serious problem in native African cultures and among African immigrants; with vulnerabilities that influenced numerous community and economic traditions, which one of them is marriage and matrimony. He said:

> Most importantly, mental illness is considered one of the major physical conditions that contributed to a termination of marriage proposal. The individual with mental illness is stigmatized and the family members suffer the stigmatization also, with permanent description of vulnerabilities to mental illnesses. Conversely, if the person were married before becoming sick with mental illness, marriage would be automatically dissolved or allowed to disintegrate based on culture. I deemed this to being informative to why the general population, family members would not show much resemblance to individuals who are taken in for mental illness treatments. The family members would not want to relate to their family member who had crossed the most advantageous cultural line of demarcation. Regrettably, indiscriminate stigmatization of individuals with mental illnesses and their families most of the time extended above the family to become a village, community, and a clan calamity.

Barriers to seeking treatment. Participants described their major experiences of impediments that prevented individuals from seeking mental illness treatment and offered their responses. P6 said:

> Advocates are asking for culturally sensitive, linguistically, and culturally competent effective mental health services to improve utilization and effectiveness of treatment alternatives for ethnically diverse minority immigrant population groups, including Africa immigrants. Without, culturally competent services, the failure to serve racial and ethnically diverse minority immigrant population groups including African immigrants effectively will become worst based on the enormous demographic growth among these population groups expected over the next number of years.

To confirm, the impediments to seeking treatment among African immigrants. P5 asserted:

> African immigrants are under-represented in mental health professionals' population who generally understand very little concerning their cultural beliefs, values, and backgrounds of the individuals they are treating, with the traditions of healing and real meaning of mental illness in their cultural perspectives.

Meaning of Help-Seeking Experience

The data revealed that meaning of help-seeking had several dimensions. Each of these is identified and described with support content from the participants. Overall, these dimensions reveal a very different way of conceptualization meaning of help-seeking experience that goes beyond the superficial differences**.**

African experience. In the African cultural belief systems, mental health problems have no cure and are transmittable based on the revealed cultural belief factors: and as a result, individuals with mental health problems are discriminated against and separated from the general population. Consequently, help-seeking is misunderstood. Participants described their major experiences and offered responses. P1 commented:

> Mental health problems still bear great stigma in African cultures, therefore individuals with mental health issues particularly will revert to spiritual and other traditional healing methods, some based in primitive cultural practices, before seeking mental health treatment from modern mental health systems.

Additionally, P2 offered the following response on the matter, adding:

> Even though there are mental health facilities in his native African country where individuals with mental health issues can go to seek-help from mental health professionals and psychologists, people prefer to do various things based on their cultural belief systems.

Traditional methods of treatment. There are the long-established curative techniques in African cultures provided by traditional medicine practitioners, spiritual and divine healers with strong beliefs that existence and activities of witches, ancestral spirits, sorcerers, and diviners influence an individual's wellbeing. Participants described their major experiences and offered responses. P4 mentioned:

> Mental health problems are stigmatized conditions among Africans and African immigrants. Individuals with mental health problems and their families reverted to spiritual and traditional healing systems, developed from primitive cultural

> practices with different conceptualizations of mental health problems to the Western/American conceptualizations. Most significantly, the traditional healers centered their therapeutic objectives based on their understanding of the problems without contributing efforts of their beneficiaries.

P9 added:

> Individuals within the spectrum of the mental health abnormality commonly referred to by the general population to be suffering from craziness, madness, and mental illness. However, as ignored as the mental health issues are in African cultures, the significant dissimilarity when comparing United States. and African countries is that individual wills seek-help or the family members will seek-help from the traditional sources for that individual.

U. S. experience. Participants understood that the U.S. through American mental health system offers services and treatments which are available for all, however, African immigrants under-utilized these services. As a public health professional, P6 offered:

> African immigrants believe that the American mental health care system is not well equipped to meet the mental health needs of the ethnically diverse minority immigrant population groups. Africans do not recognize indicators of mental health and mental illness in the same way the three domains that they represent including emotional well-being, psychosomatic well-being and social well-being.

Cultural influences. The help-seeking experience is also influenced by cultural perceptions. Most participants described that the services modalities were mostly

developed for the main-stream White population group. Further, the idea of seeking help is not culturally relevant. P5 stated:

> Mental health issues are not openly talked about in my culture; a person with mental health problems will only be addressed as having personal issues; African cultural beliefs and values of collective help give dignity to individuals regardless of their level in life. In many of the different languages from the continent, there is no word for being alone.

Utilization of services. The African immigrants' experience of mental health services utilization in the U.S. was described as "unwieldy," perplexing and lacking processes that bridge cultural differences. P1 asserted:

> Mental health care services' utilization rates vary by nativity and across racial and ethnic groups including African immigrants. African immigrants have lower rates of utilization of mental health care services for both mood and anxiety disorders. My perception of mental health problems explains my help-seeking behavior and unwieldiness to share my mental health problems with other people, African cultures believe that mental health problem has no cure and it's contagious, based on the revealed cultural factors, individuals with mental health issues are discriminated against, isolated, and separated from dealing with the general population.

Barriers and implications. This dimension is best characterized for understanding the inconsistencies in mental health care services linked with cultural barriers to help-seeking that include stigma associated with mental illness, limited

English ability, challenges to navigate the American mental health system for African immigrants, alternatives mental health care and treatment that could be inconsistent for African immigrants. All participants described their major experiences and offered their responses. For example, P1 stated that "I am not persuaded with confirmed unwillingness to seek mental health care in the U.S., because the process is different from my native African country." P8 offered the following response:

> In my experience with American mental health system, African immigrants believed that the American mental health care system is not well equipped to meet the mental health needs of the ethnically diverse minority immigrant population groups. African immigrants suffered from blocked accessibilities to mental health care services and treatments, hence individuals with mental health issues and their families are forced to be dependent on self-sufficiency with psychosomatic well-being.

P5 stated:

> Implications of lack of medical insurance, underinsurance, lack of culturally competent mental health professionals, lack mental health professionals from ethnically diverse minority immigrant population groups, distrust of American mental health system, and stigma associated with mental illness barriers for help-seeking for mental health problems among African immigrants.

The Experience of Prejudice and Discrimination in Mental Health

The data revealed that this content area had several dimensions

Sensitivity and discrimination. This dimension is best characterized for understanding racial discrimination and prejudice in mental health services. Different issues of race and ethnicity were brought up on several occasions because of the lack of cultural sensitivity. P7 declared, "African immigrants expect to be cared for by a medical doctor or a psychologist and dislike the wide-spread utilization of other mental health clinicians." P9 stated that, "the American mental health system is not well equipped to meet the mental health needs of the ethnically diverse minority immigrant population groups." Additionally, P7 thought that needs of African immigrants are, "…at odds with the American mental health system; many African immigrants indicate that they prefer a mental health professional who shares their cultural background." P3 went on to say that, "even if individual members of African immigrant population group succeed in accessing mental health care services, their treatment may be inappropriate to meet their treatment needs." P9 emphasized that the, "cultural proscriptions caused complexities for African immigrants to be using available mental health care services and treatments." P6 said:

> The lived experience descriptions of African immigrants with mental health issues demonstrate a constellation of barriers that prevent African immigrants from reporting mental health problems and seeking treatment due to systemic racism. Because time for individuals of African ancestry is circular and not linear, the mugging of slavery is still as significant as it was during that time. These assertions may strongly influence African immigrants' underlying problems of acculturation, economic and social stigma, prejudice, and discrimination, which

are contributing factors to mental health, mental illness, and help-seeking problems.

Assessment and diagnosis issues. This dimension is best characterized by the experiences of African immigrants getting inaccurate psychological assessments and incorrect diagnoses. Participants described their major experiences and offered their responses. For example, P6 stated that, "African immigrants are more likely to be diagnosed with chronic and persistent, rather than episodic, mental health conditions." P1 said:

> African immigrants are more often diagnosed with schizophrenia and less often diagnosed with mood disorders compared to the main-stream White people with the similar symptomatic complications. Additionally, African immigrants are offered psychopharmacology treatments and psychotherapies at the lower rates than the broad-spectrum main-stream White population.

Occurrence of Indigenous Cultural Stigma in Mental Illness

This content area had several dimensions. Each of these is identified and described with supporting content from the participants. Overall, these dimensions revealed a very different way of understanding that the occurrence of indigenous stigma in mental illness goes beyond the superficial differences**.**

Stigma and culture. African immigrants are influenced by their cultural beliefs concerning stigma of mental illness and their attitudes about individuals with

mental illness and their families. All participants described their major experiences and offered responses. P4 stated:

> Among African cultures, traditional cultural factors enhance stigmatization of individuals with mental illness and their family members and claim them as crazy. Mental illness tops the list of stigmatized public health conditions in African cultures and among African immigrants to the U.S.

P5 added:

> The impression of mental illness changed, among the ethnically diverse minority immigrant population groups including African immigrants; emboldened by the principles of protected family systems, individual thoughts, and traditional cultural beliefs. Culturally integrated religious teachings influenced beliefs concerning the contributing factors and nature of mental illness, and shaped attitudes towards individuals with mental illness and their families. African cultures exert stigma on mental illness and individuals with mental illness are stigmatized with their families.

P8 also stated:

> African cultures do not believe that mental illnesses are medical problems with public health concern, and not a disgraceful condition. With aggravated stigmatization, discrimination, and prejudices towards individuals who reported mental illness symptoms and their families. Stigmatized individuals and their families develop internalized feelings of disgrace and self-label of being socially undesirable

Shame and disgrace. African cultures placed a high value on social status and reputation. Individuals with mental illness and are helped by family members until they are not able to help anymore. African cultures support rejection of the individual when help reaches the point of saturation. Participants described their major experiences and offered their responses. P5 offered the following response:

> Lower socioeconomic conditions, sequentially, are linked with mental health problems. Some African immigrants who are impoverished, dispossessed, imprisoned, or have alcohol and substance abuse problems are at higher risk for having mental health problems, mental illness, and challenges for seeking help and not getting the necessitated help. Family members reject some individuals with mental illness that need help when their condition becomes worse than they can handle. Some families dump their relatives with mental illness at the hospital and never return to see how they were coping with their treatment.

P6 said:

> In most instances, embarrassments supersede even the most distressing symptomatic complications of mental illness; because mental illness is perceived as an individual disaster brought by a discord of wrongdoing, like lack of faith in one's god and being possessed by angry spirits above human control.

Attitudes towards treatment. Participants agreed that African immigrants do not trust the Western methods of treatment and do not consider mental illness to be a medical issue; therefore, they prefer to treat mental illness with traditional approaches. Participants described their major experiences and offered responses. P2 stated:

> In African cultures, mental illness is not only a problem for individuals and their families, but a problem that threatens the unanimity and relationships within the general public, while the focus on treatment is on the traditional healers, family members are accustomed to taking individuals with mental illness to traditional medicine healers and traditional native doctors before they think of going to hospitals and mental health treatment facilities.

P7 saw that attitudes towards treatment came from what African immigrants preferred, saying:

> African immigrants seek out recognizable help from their family members and used spiritual beliefs and culturally prescribed traditional practices as social support and synchronization of meaning during times of emotional distress. This affected their utilization of accessible mental health services and treatments.

Social cost of stigma. The significance of stigma of mental illness among African immigrants was reported by most participants. For example, P4 stated that:

> Stigma of mental illness tops the list of stigmatized mental health and physical well-being conditions in African cultures and among African immigrants to the United States; generating the categories of stereotypes, fear, and rejection that are reminiscent of longstanding attitudes of assuming that individuals with mental illness are crazy.

P7 said:

> Stigma is a component of African cultures that generates different kinds of stereotypes, fear, rejection, isolation, humiliation, and discrimination for

> individuals with mental illness and their family members, with barriers to seeking treatment. African culture performed the most important function and influenced Africans and African immigrants' attitudes concerning mental illness, the actuality is that no ethnic group could afford to disregard the significances, economic impediments, and individual consequences of mental health disorder or mental retardation.

P9 stated:

> Stigmatization and discrimination of individuals with mental illness and their families are uncontrolled in my native African country, due to lack of appropriate information on mental health issues that is not linked with cultural stigma, the treatment given to individuals with mental health disorders is not the same treatment given to individuals with other medical conditions.

Occurrence of Indigenous Cultural Stigma in Help-Seeking Experience

In the previous section, the emphasis was on how mental illness stigma was experienced within the culture. This experience gets more complicated as participants reached out to their family members for help-seeking necessitates.

Ordeals for family members. This dimension is characterized by understanding the ordeals generated by stigma for the family members. Two participants offered the following responses. P7 discussed how help-seeking started from reaching out to the family members, saying:

> This affected their utilization of accessible mental health services and treatments. African immigrants have culturally specific perceptions of stigma concerning

> their conception of mental illnesses that proscribed the help-seeking processes and make different modalities of treatments culturally ineffective and unacceptable. Due to these conditions, individuals depended solely on their family members for their help-seeking necessitates.

P8 stated:

> Amongst African cultures and African immigrants' occurrence of indigenous cultural stigma in help-seeking caused intolerance and discriminatory treatments of individuals with help-seeking needs for mental illnesses, increased denial of civil rights and unnecessary responsibilities from individuals. Stigmatization caused major problems for individuals that encompassed denied access to essential public resources, accessibility to equal opportunity employment, and affordable housing privileges.

Barriers to seeking treatment. This dimension is best characterized by understanding stigma of mental illness with evident among African immigrants. Participants described their major experiences differently and offered responses. P4 offered the following response:

> Stigma of mental illness denotes implications of ongoing discrimination, prejudice, and humiliation that encompasses the stigmatized individuals with mental illness and their families to undermines the help-seeking process and ultimately obstruct recovery process.

P6 was very elaborate and detailed in his reply, which is rich with the identification of psychological, social, and cultural barriers, stating:

> Despite the accessibility of mental health care services and treatments with accommodating mental health professionals, African immigrants consistently faced with multiple impediments to acceptable and effective mental health care services and treatments which are not experienced by other cultures. My careful itemization of these impediments encompassed the following: disgrace and dishonor connected with mental health problems, differentiations in expression of manifesting symptoms and ascriptions with differing concepts concerning the causative factors of mental health issues and culturally supported coping skills, lacking accessibility to relevant and culturally perceptive mental health care services in indigenous African languages, accessibility to indigenous African interpreters and language dissimilarities impact on the quality of interactions between mental health professionals from other cultures, shortage of the ethnically diverse minority immigrant mental health professionals of African ancestry with multi-culturally and diverse competencies, complexities of disclosing immigration status to mental health professionals and recurrent moves to look for equal opportunity employment.

Misunderstanding of help-seeking. This dimension is best characterized for understanding with evident misinterpretation of seeking treatment for mental illness among African immigrants. All participants described their major experiences and offered responses. P2 stated:

> African immigrants' help-seeking behaviors are affected by mistrust of the American mental health system and often begin with seeking help from

> traditional healers and faith-based spiritual healing outreach sources. African traditional healers' roles of providing cure for mental illness is controversial and their curative techniques differ from traditional Western/American approaches based on psychological and psychiatric sciences their services are highly appreciated and with unremitting utilization. These are long-established assortments of curative techniques and support for mental illnesses provided by African cultures' traditional healers that include performing rituals with aim to maintain the well-being of a whole community.

The Experience of the Participant

This content area focused on participants direct experiences, as patients or observers of the struggles African immigrants have encountered.

Mental health problems and treatment. This dimension is best characterized for understanding mental health issues with evident among African immigrants. Participants described their experiences and offered responses. P7 shared:

> My notion of mental health differed with the other cultures but embedded within the significant sagacity of Africans and African immigrants' traditional cultural belief systems and ways of life that shaped the justification to dissimilar understandings of pragmatism. African immigrants' mental health problems cannot be addressed by mental health professionals from other cultures without taking into consideration the comprehensive cultural implication and meaning. Within African countries, there is a significant ongoing argument concerning the dependability of imposing Western/American conception of mental health

treatments on African countries and inflamed confrontations from Western/American mental health professionals to the appropriate help-seeking trend for mental health issues and African traditional healer's accountability.

P4 stated:

> African immigrants faced a difficult life in the United States, daily stressors wear on their strength and their mental health. Anxiety and mood problems carried a significant individual and collective encumber among African immigrants. The chronological prevalence of mood and anxiety problems among African immigrants could not be addressed appropriately when considered through the conception of traditional cultural belief systems. Mental illness symptoms could affect emotions, thoughts, and behaviors among African immigrants; generate confused pattern of thinking, reduced abilities to concentrate, withdrawal from families, friends, and society, and inability to cope with daily stress and demands of individual daily life.

American mental health system. This dimension is best characterized for understanding with evident African immigrants' perception of American mental health system. Participants described their experiences and offered their responses. P3 offered the following response:

> African immigrants believed that the American mental health system was not well equipped to meet the mental health needs of the ethnically diverse minority immigrant population groups. The racially and ethnically diverse minority

> immigrant population groups were generally considered to be underserved by American mental health system, because of disparities in delivery of services.

P5 added insight on the topic, saying:

> African immigrants have negative attitudes towards mental health professionals in American mental health system. They do not understand their long-established cultural backgrounds, and cultural conceptualization of mental illness, which are indispensable in the development of effectual and culturally sensitive mental health care services and treatments for the ethnically diverse minority immigrant population groups including African immigrants.

Social and economic issues. This dimension is best characterized for understanding the social and economic issues that contribute to African immigrants' mental health problems. Participant described their experiences and offered their responses. P9 said:

> Misunderstanding as an African immigrant is that, while poverty is not the only contributing factor to mental health problems, economic impediment, lack of money, lack of medical insurance, fear becoming a public charge, and being reported to U.S. immigration to be processed for deportation are usually the most important reasons offered by African immigrants for not seeking mental health care service.

From a different viewpoint, P8 described how social and economic issues are experienced within the African community, stating:

> Stigmatized individuals and experience social and economic discrimination, seeking employment and living successfully with other individuals in a community setting. Stigmatized individuals are prevented from seeking mental illness treatment and compliance to the treatment regimens. While reason for culturally embedded stigma in help-seeking for mental illness are consistent across African cultures, known stigma of individuals with mental illness are universally reported.

P3 also elaborated on the social and economic challenges, speaking on how disenfranchised the immigrants are as a group, sharing:

> Many Africans arrive in the US as individuals, leaving behind other family members in their home countries. Most of them go through years of physical separation from those family members that were left behind in their native African countries. African immigrants engaged in long distance family relationships and sending support to them, this created significant social and economic challenges, and mental health complications. They faced challenges in getting employment, affordable housing, marital and parent-child conflicts, problems with child welfare and the criminal justice issues, social isolation, systemic racism, and structural discrimination form the mainstream culture that contributed to their range of mental health problems. African immigrants, like a significant number of disenfranchised ethnically diverse minority immigrant population groups in the United States, usually underutilized the available mental health care services and treatments.

P3 also described how these social and economic challenges create delays in reaching out for and receiving services, so mental illness conditions worsen without treatment, saying:

> African immigrants most of the time delayed help-seeking for mental health problems at community mental health care centers, until the necessitate for psychiatric emergency care and psychiatric hospitalizations became unavoidable. Rather than help-seeking from mental health professionals, psychologists, and psychiatrists, for mental health problems African immigrants would depend on informal help from traditional healers, spiritual healers, family members, friends, support groups, and seek medical-help care from general medical practitioners

Utilization of U.S. Services

The data revealed that "Utilization United States. Services" had several dimensions. Each of these is identified and described with support content from the participants. Overall, these dimensions reveal a different way of conceptualization and utilization of U.S. services that goes above the superficial differences accessing the offered services.

Racial and ethnic differences. This dimension is best characterized by seeing racial and ethnic differences as evident in mental health care services offered to African immigrants, without appropriate consideration of the procedures and outcome of the culturally competent mental health care for all immigrants. Participants described their experiences differently in affirmation to these assertions and offered their responses. P9 stated:

> Despite progress made over the years, systemic racism, racial discrimination, and prejudice continued to have an impact on the mental health of African immigrants. Negative stereotypes and attitudes of rejection are addressed, but continued to occur with quantifiable, unfavorable consequences. Past and existing occurrences of negative treatment have led to a mistrust of mental health professionals from the main-stream culture, White majority who are not seen as having the paramount interests of African immigrants in mind. There is assumption of disparity, notion that African immigrants will not be given proper treatment at community mental health clinics, this negative rumors, and bad news are made known through the whole of African immigrant's community.

Mental health professionals. This is dimension is best characterized by seeing with evident African immigrants' distrust and dislike of mental health-care professionals from other cultural backgrounds with the services that they offer. Participants confirmed these assertions and described their major experiences in different ways and offered their responses. P3 offered the following response, saying:

> African immigrants may find only White, mental health clinicians who represent a White middle-class orientation, with its mainstream cultural values and traditional beliefs, as well as its biases, misconceptions, stereotypes of other cultures, and disadvantaged ethnically diverse immigrant population groups.

P7 said:

> African immigrants feel that when mental clinicians do not effectively understand their cultural background, their expectations, and their preferences, it creates

> mistrust and suspicious feelings among immigrants and their mental health professional.

P7 went on to say that:

> Throughout the ages, most African cultures and had sought after and received mental health care services from African traditional healers, spiritual healers, and their pastors. African immigrants are practitioners of these cultures and there are good tendencies for their utilization of these services for their mental health issues, while they also expect to be cared for by a medical doctor or a psychologist and dislike the wide-spread utilization of other mental health clinicians in the American mental health system.

Cultural exclusions and inclusions. This dimension characterized understanding with evident embedded exclusions and inclusions for seeking mental health treatment in African cultures and among African immigrants.

Participants described that in their native African countries, there was a cultural provenance with stipulations that separated men and women into two main groups with different rights and treatment benefits. Individuals with mental health problems were treated by traditional and spiritual healers, medical doctors, and mental health professionals according to their sexual characteristics. P7 asserted that:

> Men were not allowed to be treated by female traditional healers, female medical doctors, and female mental health professionals. Women were not allowed to be treated by male traditional healers, male medical doctors, and male mental health

professionals. African immigrants transported this cultural provenance to the U.S. as embedded component in their cultural exclusions and inclusions for mental health help-seeking this has influenced their willingness and unwillingness to utilize accessible mental health care services and treatments in the United States. P9 described the cultural proscriptions and complexities of using available services and voiced other cultural concerns for African immigrants that include religious and gender norms, which do not allow women to be treated by male mental health professionals.

Effectiveness and acceptability issues. Participants reported how practitioners who were not trained to address specific cultural issues were rejected by immigrants seeking help. P2 stated that, "African immigrants have negative attitudes about mental health treatment because they believe that; mental health professionals from other cultures are not methodically trained to address their individual mental health needs." P3 felt that, "Mental health professionals have no understanding of the help-seeking trends of African immigrants and the condition through which individual's suffering becomes open or internalized."

Results: Second Cycle

The results of the second cycle analysis were produced by line by line analyses of the transcripts; the coding process was described above. The results of this analysis were very consistent with and confirmed the first cycle analysis experience. The table and subsequent quotes arranged the concepts slightly different, but with considerable overlap to the findings of the first cycle. There were eight categories, with dimensions under each category, and these are represented by quotes and summaries in the discussion below.

Table 4

Results of Second Cycle

Categories	Dimensions
Assumptions and Expectations	• Mental Health Professionals • Cultural Exclusions and Inclusions • Effectiveness and Acceptability Issues
Importance of Cultural Understanding	• Stigma and Culture • Significance of Social Status • Attitudes Towards Treatment • The Cost of Stigma
Experience of Mental Health	• Unique Conception of Mental Health • Family/Community Connection • Believes in Traditional Approaches of Healing • Utilization of Services
Cultural Experience of Mental Illness	• Unique Conceptions of Mental Illness • Challenging Life Issues • Cultural Judgments • Barriers to Seeking Treatment
Meanings of Help-Seeking	• African Experience • United States Experience • Cultural Influences • Barriers and Implications
Dissatisfaction	• Traditional Methods of Treatment • Disparities in Mental Health Services • Racial Prejudice and Discrimination • Accessibility to Mental Health Services • Assessment and Diagnosis Issues

(table continues)

Categories	Dimensions

Subject of Story	• Mental Health Issues • Mental Illness and Treatment • American Mental Health System • Social and Economic Issues
Participant Occupation	• Stigma of Mental Illness • Symptomatic Complications • Cultural Perspectives on Mental Illness • Misunderstanding of Help-Seeking

Category 1: Assumptions and Expectations

The data revealed that this category had several dimensions. Each of these are identified and described below with support from the participants' descriptions and responses.

Mental health professionals. This category reflects African immigrants' distrust and dislike mental health-care professionals from other cultural backgrounds with the mental health care services and treatments offered. Two participants responded as follows, P2 said:

> African immigrants perceived that, mental health professionals failed to understand that, their culture prescribed the significances of every phenomenon of wellbeing, and to greater extent influenced individuals' impression concerning mental health professionals from other cultures, values and norms that may negatively prevail among them. There are also cultural proscriptions for un-authentic and negative mores concerning mental health problems, mental illness, and help-seeking trends.

P6 asserted:

> African immigrants are minorities in the U.S. and are less likely to seek mental health treatment from mental health professionals from the main-stream White culture, they would wait until the manifested symptoms were severe before looking for help-seeking possibilities. There is existing and continuing complaint that, the mental health professionals from other cultures do not understand the role that culture plays in the experience and meaning of mental health care services and treatments among African immigrants. African immigrants accused mental health professionals from other cultures of failing to implement a careful consideration of their values and norms with affirmation that African immigrant families support their loved ones with mental health problems and encourage them to seek culturally available help when it is most desired.

Cultural exclusions and inclusions. This dimension focused on African immigrants' conformity with traditional cultural beliefs ascription of specific exclusions and inclusions to seeking mental health care services and treatments in the U.S. Three participants offered the following responses. P3 said:

> African immigrants have a different way of looking at mental health, mental illness, and stigmatization of individuals with mental health disorder and their families. Among most individuals there is a developing stigma around mental health, and mental health challenges are considered a limitation and something to conceal before the general population because of shame and disgrace. Stigma and concealing of mental health problems make it harder for individuals struggling

with the problem to talk openly concerning their mental health problems and request for help.

P7 shared:

> Understanding the manifesting symptomatic complications of mental illness is a major problem among African immigrants. Culture influenced how individuals described and feelings concerning their symptoms. Culture could affect whether someone chooses to recognize and talk concerning only physical symptoms, only emotional symptoms or both. Cultural factors determine how much support someone gets from their family and community when it comes to mental health. Because of prevailing stigmatization of individuals with mental health problems and their families, individuals are sometimes left to find mental health treatment and support services alone privately from the community traditional and spiritual healers.

P8 stated:

> What materialized expressively in African immigrants' reflections concerning mental health and traditional cultural beliefs are not always understood by other cultures because of cultural discrimination and prejudice. Generally, between African immigrants, these reflections remained centered on the thoughts of what could be done to explain how their cultural beliefs inform their notion of mental health experience to other cultures, alongside their different food and eating traditions, exclusive different languages and lingua franca, unique clothing and customs of colorful dressing. These are the best ways to explain myself with

> clarity for better understanding; among African immigrants, individual's behavior and concepts of emotional wellbeing are all impacted by culture, meanings of mental health, mental illness and help-seeking impacted by culture, individuals' willingness and unwillingness to seek treatment, accessibility of treatment, effectiveness of treatment, and the community support available for the individual with help-seeking needs are all influenced, informed, and impacted by cultural background embedded with established collectivists principles and values."

Effectiveness and acceptability issues. African immigrants were concerned of effectiveness and acceptability of the mental health care services and treatments offered to them by mental health professionals from other cultures within American mental health care system, and community mental health centers. P7 said that, **"**African immigrants also have high demands for mental health professionals that are at odds with the American mental health system; many African immigrants indicated that they preferred a mental health professional who shares their cultural background." P9 stated:

> My perception is that long-established cultural beliefs, concept of wellness, language differences, and spirituality must be recognized as entangled primary contributing factors to mental health care services and treatments experiences of African immigrants to the U.S. Additionally, deficiencies of available multi-culturally-competent mental health professionals, mistrust, and involvedness, of the American mental health system, inappropriate distribution of services, and the exorbitant cost of obtaining effective and acceptable mental health care

> services and treatments must also be acknowledged as the most important accessibility impediments to obtaining a culturally sensitive and effectual mental health care services and treatments among African immigrants. There is also a confirmed assumption among African immigrants, that, mental health professionals from the main-stream White culture do not recognize and respect their cultural identity at the time of mental health assessment, and the significant deficiencies of reported information concerning their mental health care services and treatments utilization experiences in the U.S.

Category 2: Importance of Cultural Understanding

The data revealed that this category had several dimensions. Each of these is identified and described below with support from the participants' described experiences and responses.

Stigma and culture. Cultural stigma of mental illness conveyed the mark of disgrace and shame borne by individuals with mental illness and their families in native African cultures and among African immigrants. P5 said:

> African immigrants believe that depression is the most common type of mental illness conditions, but in their native African cultures, traditional cultural beliefs do not support the perception, despite the fact that depression is one of the leading causative factors of disability all through the worldwide countries and the U.S.

P6 said, "Mental illness is an individual disaster brought by a discord of wrongdoing such as lack of faith in one's god and being possessed by angry spirits above human control."

P9 said:

> In African countries many individuals suffer silently from one of the most ignored and misunderstood categories of public health pandemic which is mental health problems, and only a selected few of those individuals affected are considered good enough for help-seeking, the rest are deemed to be psychologically unfit for help-seeking.

Significance of social status. The significance of social class in African cultures and among African immigrants' proscribed interactions with individuals with mental illness and their families. P4 stated that, "Mental illness is perceived as a public embarrassment condition that could damage peoples' reputations; hence individuals suffering from mental illness and their families are less expected to be given assistance because of damaged social status." P7 expressed thoughts on the matter by saying, "African cultures do not believe that mental illnesses are medical problems, public health conditions, and not a disgraceful circumstance." P9 added:

> There is a widespread belief linking mental illnesses to supernatural causes including witchcraft, demonic possession, and ancestral gods, we believe that mental health clinicians represent a White middle-class orientation with main-stream cultural values and traditional beliefs as well as biases, misconceptions, stereotypes of other cultures, and disadvantaged ethnically diverse immigrant population groups.

Attitudes towards treatment. African immigrants' attitudes towards treatment differed from other individuals in distinctive ways. P4 stated, "There is established

practice of racial discrimination included in mental health policies of private and governmental mental health institutions that intentionally restrict the opportunities of individuals with mental illness and their families from getting mental health care services." P5 said:

> African immigrants disbelieve that the American mental health system, in the mental health care and public health arena put more importance and resources committed to psychological assessment, establishing diagnosis, and treatment of mental illness than mental health. We felt that little has been done by American mental health system to protect the mental health of African immigrants who are free of mental illness, while ignoring the critical point which is the utilization of mental health care services at the most needed time.

The cost of stigma. The cost of stigma was a significant barrier that prevented African immigrants from seeking mental illness treatment. Participants described their experiences in different ways and offered the following responses. P9 said, "There is lack of appropriate information on mental health issues that is not linked with cultural stigma, the treatment given to individuals with mental health disorders is not the same treatment given to individuals with other medical conditions." P8 affirmed community involvement and mentioned:

> Depending on every community, an individual with mental health issues is taken in for oracle consultation; they use local medicine to treat the individual. Some address the issue by taking this person to the herbalist, but this depends on the cultural beliefs of the family.

He went on further to say, “Sometimes, the family does not know what is going on; they thought the person with mental health issues was just making intentional gestures different from manifesting symptomatic complications of the infirmity initially and believed that prayers were effective.”

Category 3: Experience of Mental Health

The data revealed that this category had several dimensions. Each of these is identified and described below with support from the participants’ described experiences and responses.

Unique conceptions of mental health. African immigrants have different conceptions of mental illness embedded with physical, social and cultural ways of life. P1 said, “[The] Mental health issue in my native country is distinctively different from the construct of mental health in the United States.” The American conceptualization of mental health is described in terms of discrete emotional, cognitive, behavioral aspects of daily life. Participants in this study described mental health as more holistic. P7 stated that, “African cultures accept that mental health is linked to many other physical conditions: therefore, mental health is the basis of all preventive medicines in terms of physical illness.”

Family/community connection. African immigrants supported deep the family/community connection with mental health. P6 postulated, “African cultural beliefs and values of collective help give dignity to individuals regardless of their level in life. In many of the different languages from the continent of Africa, there is no word for being alone.” He further mentioned that, “Africans’ collective approach to human behavior

emphasizes collective responsibility, shared concern, and commitment to a common cause, a family that is a community center for better." To further ascertain the concepts of relationship with family and the public. P5 expressed:

> While there are individuals of African ancestry in the U.S. whose families have in African community settings in the U.S. for over hundred years, there is a significant need to understand that their ancestors did not willingly come to the shores of this country.

Beliefs in traditional approaches of healing. This dimension is characterized evident for further authentication of the Results reported in the First Cycle, that beliefs in traditional approaches of healing were long long-established curative practices in African cultures and among African immigrants. P3 explained, "However, as ignored as mental health issues are in African cultures, the significant dissimilarity when comparing U.S. and Africa is that individual will seek help, or the family members will seek help from the traditional sources for that individual." P5 described mental health care in his native African country by saying:

> In my native African country, mental health and mental illness treatments are handled by herbalists of native doctors, I mean not in the hospital setting because I have never seen any hospital called mental health hospital, I have never seen one.

Use of services. African immigrants' utilization of services in the U.S. was unachievable complicated and challenging processes bridged by cultural differences. P4 responded, "African cultures believe that mental health problem has no cure and it's

contagious. Based on the revealed cultural factors, individuals with mental health issues are discriminated against, isolated, and separated from dealing with the general population." P6 added, "African immigrants disbelieve that the American mental health system, in the mental health care and public health arena, put more importance and resources committed to psychological assessment, establishing diagnosis, and treatment of mental illness than mental health."

Category 4: Cultural Experience of Mental Illness

The data revealed that this category had several dimensions. Each of these are identified and described below with support from the participants' descriptions and responses.

Unique conceptions of mental illness. African cultures and African immigrants disbelieved American conceptualization of mental illness as a diagnosed medical condition, public health condition, and not a condition of humiliation and embarrassment. P1 stated that, "In my native African culture, mental illness is prohibited from being addressed openly in all circumstances." Furthermore, depression and stress are not considered to be mental illnesses in the same way that they are in the U.S. P8 said:

> African cultures put the burden of taking care of individuals with mental illness on the family members, and when they are not able to deal with care taking problems any longer, individuals are always placed under the care of trained mental health professionals.

Challenging life issues. Challenging life issues faced by African immigrants were contributing factors of mental illness. African immigrants have possibilities of being

deported because of criminal conviction than other minority immigrants. P5 described the challenging experiences and offered the following response:

> While mental health problems and mental illness do not discriminate, the American mental health system does discriminate, African immigrants have less access to mental health care service, although less likely to seek treatment due to poor quality of treatment, higher levels of stigma, language barriers and dissimilarities, lower rates of health insurance or no insurance, racism, prejudice, and discrimination in treatment settings, and culturally homogeneous mental health care system.

P7 added:

> African immigrants faced innumerable challenging life predicaments interconnected with the challenges of native-born African-Americans that encompassed systemic racism, prejudice and racial discrimination, housing discrimination, employment discrimination, disproportionate equal representation in the mental health professionals, mental health care services and treatments, and criminal justice systems. I deemed it better with affirmation that, I have paid my price for living in the U.S. African immigrants expected none of these challenges that they met until they were confronted with the challenging predicaments in actualities. Additionally, the challenging life issues faced by African immigrants are embedded with the following problems: Language barrier problem, a significant challenging issue faced by African immigrants which had being a problem and will continue to be a problem because African immigrants are regarded as second English language speakers even though English is official

language in their native country. Employment problem, African immigrants, experienced and inexperienced equally faced challenges in getting employment in the U.S., contrary to their beliefs and expectations, they quickly realized that it was not easy for them to find employment. African immigrants' academic qualifications and professional experiences regrettably are not willingly accepted for employment in the U.S. due to prejudice and racial discrimination. African immigrants faced challenges in putting their children in school because of immigration status conditions and English requirements for their children. African immigrants faced lack of information and accessibility to essential services, and mental illness resources and treatments.

Cultural judgments. Cultural judgments influenced and informed African cultures and African immigrants on experience of mental illness. P5 offered the following response:

> That impinged upon the use of mental health care services among African immigrants and concluded: there is prevalence of challenging acculturation, social-economic and cultural problems that influence African immigrants' mental health, making them vulnerable to mental illness, whether we like it or not, we must still recognize that in America, there is still issues of racism or prejudice and something you never used to or wished to look to them as relevant with yourself.

P6 asserted:

> African immigrants though incongruent from other immigrants faced multiple cultural judgments in the U.S., itemized to include complexities in speaking

American English, challenges in getting time off from work due to economic necessitates, and restricted alternatives of transportation are existent time issues aggravated by cultural judgments. Accessibility to mental health care services and treatments are significant challenging conditions faced by African immigrants. Most if the time, African immigrants had been exposed to violent behaviors of physical abuse, human suffering, molestation, and sexual abuse which they did not know how seek-help through contact with law enforcement agencies.

Barriers to seeking treatment. Barriers to seeking treatment among African immigrants were aggravated by multiple factors including their traditional cultural beliefs. P2 said, "The Western/American construct of mental health and managing mental illness with non-culturally homogeneous developed methods of treatment keep African immigrants away from reporting mental health problems and seeking help." P6 added, "Advocates are asking for culturally sensitive, linguistically, and culturally competent effective mental health services to improve utilization and effectiveness of treatment alternatives for ethnically diverse minority immigrant population groups, including Africa immigrants."

Category 5: Meanings of Help-Seeking

The data revealed that this category had several dimensions. Each of these is identified and described below with support from the participants' descriptions and responses.

African experience. African immigrants had different meanings of help-seeking in their native African countries before migration to the U.S. P1 stated:

> Mental health problems still bear great stigma in African cultures, therefore individuals with mental health issues particularly will revert to spiritual and other traditional healing methods, some based in primitive cultural practices, before seeking mental health treatment from modern mental health systems, individuals with mental health problems are discriminated separated from dealing with the general population and misunderstanding of help-seeking.

P2 recalled that even though there are mental health facilities in his native African country where individuals with mental health issues can go to seek-help from mental health professionals and psychologists, people prefer to do various things based on their cultural belief systems.

U. S. experience. African immigrants' experience of help-seeking in the U.S. differed from experience in their native African countries. American mental health system offered mental health care services and treatments which were available for all that could help assuage the social and economic outlays of mental illness problems, but African immigrants under-utilized these services. P6 stated:

> African immigrants believe that the American mental health care system is not well equipped to meet the mental health needs of the ethnically diverse minority immigrant population groups. Africans do not recognize indicators of mental health and the three domains that they represent including emotional well-being, psychological well-being and social well-being.

P9 African immigrants have high expectations concerning mental health professionals. They are at odds with American mental health systems. Most African immigrants

indicate that they prefer mental health professionals who share their cultural background and understand their problems.

Cultural influences. Cultural influences impacted African immigrants' concept of mental health, mental illness, and help-seeking trends. P5 stated:

> Individuals who desire help-seeking for mental illness will likely revert to prayers and other traditional healing methods like traditional medicine practitioners and faith and spiritual healers before going to Western-educated mental health professionals for psychological assessment, established diagnosis, and treatment.

P8 said:

> My concerns are that through personal understanding of our cultural beliefs, there is no authentication that mental illness is real psychological predicament that needs to be addressed appropriately by qualified mental health professionals, my cultural concerns as an African immigrant include religious and gender norms, which do not permit women to be treated by mental health professionals.

Barriers and implications. African immigrants faced barriers and implications with help-seeking needs in the U.S. P3 responded:

> African immigrants who do not have information about American mental health systems and mental health resources do not always know where to go to seek help, but most of them end up at the hospital as the last alternative when their condition becomes worst.

P4 stated:

> I was denied treatment at the community mental health clinic because I was a foreign-student with no green card, no medical insurance, and no money to pay; I internalized the denial and linked it with prejudice and discrimination faced by individuals suffering from mental illness, which leads to feelings of embarrassment and label as socially undesirable in some cases because embarrassment overrides even the most tormenting symptomatic complications of mental illness.

Traditional methods of treatment. Traditional methods of treatment in African cultures were carried by African immigrants to the U.S. P3 said that, "Traditional therapists who provide traditional healing for mental illness have been in business throughout the ages even before colonial times. Their healing techniques are not written but vary among spiritual healers and native doctors." P3 added:

> Family members usually hide individuals with mental illness in the house because mental illness is presumed to be a disgraceful infirmity; when the problem becomes unbearable, the family members secretly rush the individual to a traditional healer to be accepted with no conditions, no demands for insurance, no personal information, no family history, and no money.

Category 6: Dissatisfaction

The data revealed that this category had several magnitudes. Each of these is identified and described below with support from the participants' described experiences and responses.

Disparities in mental health services. Disparities in mental health services created impediments for African immigrants getting effective mental health care services and treatments. P6 expressed that, "Without culturally competent services, the failure to effectively serve racial and ethnically diverse minority immigrant population groups will become worse based on the enormous demographic growth among these population groups expected over the next number of years." These impediments among African immigrants were substantiated in the following way, according to P5, who shared:

> African immigrants are under-represented in mental health professionals' population who generally understand very little concerning their cultural beliefs, values, and backgrounds of the individuals they are treating, with the traditions of healing and real meaning of mental illness in their cultural perspectives.

Racial Prejudice and Discrimination

Prejudice and racial discrimination, systemic racism and bigotry faced by African immigrants prevented them from seeking mental health care services and treatments in the U.S. P5 said:

> Whether we like it or not, we must still recognize that in America, there is still an issue of racism or prejudice and something you never used to or wished to look to them as relevant with yourself, you resented them, and through that you can develop the sense of inferiority complex that can develop to other mental health problems in one's life.

P5 also said:

> African immigrants have less access to mental health care service, although they are less likely to seek treatment due to poor quality of treatment, higher levels of stigma, language barriers and dissimilarities, lower rates of health insurance or no insurance, racism, prejudice, and discrimination in treatment settings, and culturally homogeneous mental health care system.

Accessibility of Mental Health Services

Challenges of accessibility to mental health care services prevented African immigrants from seeking mental health care services in the U.S. Three participants described their experiences and noted some of the striking differences between American culture and their descriptions of how mental health occurs in their cultures. P1 stated, "African cultures believe that mental health problem has no cure and it's contagious. Based on the revealed cultural factors, individuals with mental health issues are discriminated against, isolated, and separated from dealing with the general population." P2 stated:

> Africans do not talk about mental health problems, but this is distinctly different, where Americans are quite comfortable and expect mental health, distress, and help-seeking to be a part of conversation; this could be exacerbated by the circumstance of coming to a new culture and the complications that the adjustment process creates.

P5 said, "While there is up-and-coming confirmation that positive mental health is connected with improved health outcomes, this assertion may not apply to African

immigrants who are known for unimproved health outcomes due to life complications facing them in the U.S."

Assessment and Diagnosis

There were confirmed actualities of African immigrants getting wrong psychological assessments, misdiagnosis for mental illnesses, and wrong treatment alternatives. P1 said:

> African immigrants assumed that mental health professionals from other cultures were not familiar with the progression of their cultural configuration of implications; wrongly assessed them as psychopathology, with consistent differentiation in their beliefs, behaviors and experiences which are challenges to African immigrants' cultural beliefs. African cultures and African immigrants have differed in concept with the Western conceptualization of mental illness.

African cultures labeled Individuals with mental illness as socially undesirable. P7 concurred that, "African immigrants do not trust the mental health professionals who perform psychological assessment, establish diagnosis for mental illness, and make treatment decisions that cannot communicate in languages other than English with African immigrants whose first language is not English." P8 stated:

> The significant problems concerning mental health services, psychological assessments, mental health diagnoses, and treatment alternatives common among African immigrants are that, the quality of care is poor, they are not able to participate in making treatment decisions due to language barriers and cultural

differentiations, they have no understanding about the legitimacies of assessment, diagnosis, and treatment.

Category 7: Subject of Story

The data revealed that this theme had several dimensions. Each of these is identified and described below with support from the participants' described experiences and responses.

Mental health issues. Mental health issues prevailed among African immigrants. This was indicated by P5 who said, "While there is up-and-coming confirmation that positive mental health relates to improved health outcomes, this assertion may not apply to African immigrants who are known for unimproved health outcomes due to life complications facing them in the U.S." According to P1:

> African cultures accept that mental health is linked to many other physical conditions; therefore, mental health is the basis of all prevention medicines in terms of physical illness. Participants also noted some other striking differences between American culture and their descriptions of how mental health occurs in their culture.

P3 stated, "Mental health issues are highly stigmatized conditions among African immigrants, and most individuals with mental health problems revert to traditional healing methods based on their traditional cultural practices before seeking mental health treatments from Western/American modern systems."

Mental illness and treatment. African immigrants have dissimilar notions for mental illness and treatment from other individuals. P6 shared that, "African cultures

have many misconceptions concerning mental illness, some individuals' associate mental illness with traditional harmful practices, and others attribute it to evil spirits, wondering and rebellious messengers of traditional deities, and blame individuals with mental illness." In addition, P9 said, "There is a widespread cultural belief linking mental illness to numinous causes including witchcraft, demonic attack, possession by ancestral deities, and wrongdoings of individuals against humanity."

American mental health system. African immigrants failed to trust American mental health system with the services provided by main-stream mental health professionals. According to P5, "African immigrants believe that there is a significant problem concerning the insufficiency of American mental health system diagnostic implements which are not constructed on culturally broad-spectrum models which are not to their advantage." P9 followed up by stating, "African immigrants have high expectations concerning mental health professionals; they are at odds with American mental health systems."

Social and economic issues. Social and economic issues faced by African immigrants prevented them from seeking mental health care services and treatments. P3 stated:

> Families that have individuals with mental illness suffer through public embarrassment and disgrace; people do not want to have anything to do with any family that has any person that has a mental illness because they are professed to be suffering from mental retardation that has no cure and runs in the family.

Category 8: Participant Occupation

The data revealed that this theme had several dimensions each of these is identified and described below with support from the participants' described experience and responses.

Stigma of mental illness. Stigma of mental illness (the culture of negative and demeaning views concerning individuals with mental illness and their families) in African cultures and among African immigrants constituted impediments to seeking treatment. P4 stated:

> All African cultures and African immigrants know that stigma of mental health leads to discrimination, and discrimination could be sufficiently noticeable and direct, which negative remarks are made against individuals' mental illness and help-seeking trends; other people avoid individuals with mental health conditions because of cultural beliefs assertions that they are crazy, instable, violent, vicious, dangerous and dirty, based on these assertions, individuals are forced to negatively judge themselves.

P5 said:

> In all African countries and among African immigrants, stigma of mental illness produces discrimination and prejudice in employment processes, impedes equal housing opportunities, mental health care services, community involvement, social relationships, and negatively impacts the quality of life for individuals with mental illness, their family members, and friends.

Symptomatic complications. Symptomatic complications of mental illness were misunderstood by African immigrants. P1 stated:

Mental illness is a challenging physical condition that is not accepted by the general population, and nobody wants to have anything to do with an individual who has mental illness and their families……Postpartum depression is a severe mental illness and seeking appropriate treatment for the symptoms is the only intervention for the problem; while there are cultural differentiations concerning the meaning of mental illness and manifesting symptoms, there must be understanding about effective treatment and damaging effects of untreated mental illness conditions.

Cultural perspectives of mental illness. African immigrants' faced implications of their cultural perspectives of mental illness, differently from other cultures. In the opinion of P1, "Mental illness is a challenging physical condition that is not acceptable by the general population, and nobody wants to have anything to do with an individual who has mental illness and the families." P5 added:

> Mental illness among African immigrants refers to collectively all diagnosable mental disorders and mental health conditions that are characterized by alterations in thinking, mood, or behavior associated with distress and impaired functioning; mental illness is one of leading causes of mortality and morbidity in African countries, and Africans with severe mental illness tend to die of preventable conditions 25 years earlier that Africans without such diagnoses.

P9 said:

> African cultures believe that mental illness and individual disaster are brought by the discord of wrongdoing such as lack of faith in their god, a person being possessed by angry spirits, and even accidents are believed to be under divine control of occurrence.

Misunderstanding of help-seeking. There is ongoing misunderstanding of help-seeking needs among African immigrants to the U.S. P8 shared his experience with the American mental health system stating, "African immigrants believe that the American mental health care system is not well equipped to meet the mental health needs of the ethnically diverse minority immigrant population groups." P9 said:

> Diversity has transformed the U.S. to a more motivating and open society blessed in ideas, perspectives, and improvements, but nevertheless, the future of the U.S. diverse, multi-cultural society cannot be realized until all Americans, including ethnically diverse minority immigrant population groups and African immigrants gain accessibility without disparity to effective culturally sensitive and acceptable mental health care services that meet their mental health care necessitates.

Summary

The results of this study reveal a complex, multiple-dimensional experience of mental health, mental illness, and help-seeking in African immigrants. In addition to the struggles to understand and reconcile country-of-origin views with the US vision of mental health, mental illness and treatment, participants painted a dismal view of how they experienced mental illness through the lens of their cultural experience, and of the

painful and non-responsive interactions with accessing and receiving care. The results are summarized across the two analyses and organized to answer the four research questions.

RQ1

The results of both analysis cycles revealed that African immigrants face negotiating the differences between their African country-of-origin culture and the U.S. culture. In their country of origin, mental health is a state of well-being in which several individuals realize their own abilities and manage with their stresses of life; work productively; and make constructive contributions to their communities. Africans and African immigrants perceived mental health problems as the consequence of an external attack on the individual. The subject matter of mental health is proscribed in African cultures and is considered generally unmentionable in all private and public discussions.

Africans and African immigrants come from a collectivist culture and believe that the most important characteristics in their lives were having their full family support all the time. African immigrants worried that one important component in their lives was losing the community protection formerly provided by their protective family systems. Back in their native African countries, African immigrants understood that the protective family system that helped the members overcome the challenges of mental health complications in their lives. Migration to the U.S. for better life conditions and advanced economic broad-mindedness, created the leaning to culture of individualism and abandonment of closed family systems. In addition, the social and economic problems, housing and employment inequalities, and systemic racism, influenced African immigrants' mental health in negative ways. Africans and African immigrants'

traditional cultural practices not only influenced their mental health but influenced all components of life including social functioning abilities, family relationships, and physical well-being. Africans and African immigrants' connection with traditional values and methodologies for health is unique.

One example of the influence and consequences of traditional African healing practices is illuminated by the belief that disease, illness, and poor health condition were due to bad luck. Individuals with mental health problems and their families in African countries had only two options to choose from, African traditional medicine and spiritual healing methods.

Africans and African immigrants' traditional values are embedded with traditional African healing practices, African traditional medicine, devination, herbalism, witchcraft, voodoo, and spiritualism customarily amalgamated in African traditional methods treatments, which are some of the most varied and oldest curative system in Africa and the world. Africans and African immigrants embraced African traditional methods of treatment because of the holistic approach to health in which mental health was assessed side-by-side with physical health, and availability of culturally competent practitioners and healers.

RQ2

Several interesting findings emerged in the data analysis process regarding mental illness, culture and stigma. In particular, the dimensions of Cultural Experience of Mental Illness and Participant Occupation were particularly illuminative. Of clear import among participants was the understanding that mental illnesses were distinguished as

spiritual problems instead of medical conditions. Individuals with mental illness were hidden for long periods of time in the house by their families until they were healed, for fear of shame and disgrace from their community and the general public. This process became a cycle for families, and the manifested symptoms of mental illness were not treated, and where healing took a long time or did no change, the individual would be taken to the traditional medicine practitioners or spiritual healers for culturally acceptable treatment. The participants reported the preference to utilize traditional methods of treatment for mental illness. Traditional curative methods could not be compared with approved Western/American developed mental illness treatments that utilized psychotherapy and pharmacotherapy. Most African immigrants felt that, the traditional methods of treatment would be the best curative method for mental illness because of the causative factors of mental illness.

Many participants indicated that in rural areas in Africa, individuals with mental illness were sent out by their families to protect the family legacy and name. This was done because individuals with mental illness were assumed to be a curse for the whole family. All members of the family could be ostracized if one of them is perceived to be mad or crazy. In response to questions about indigenous stigma, participants indicated that rural African cultures proscribed the marriage of girls and women from families where a family member had mental illness into other families, because of the fear that future family descendants would also be afflicted with mental illness. Most African and African immigrants misunderstood manifesting symptoms of mental illness, and instead characterized individuals with mental illness as victims of evil spirits, witchcraft, and

metaphysical complication, that victims must be taken to the traditional medicine practitioners and spiritual healers. The way things are done in the U. S. (visiting a mental health care facility, getting diagnoses and treated) s also shaped their perceptions of mental illness and help-seeking. In addition, African immigrants are not recognized as being ethnically diverse, and reported the experience of cultural discrimination, racial discrimination and hatred, ranging from racist comments to violent hate crimes.

Another interesting finding that illuminating the area of mental illness and indigenous culture stigma was the differences between African country-of-origin culture and the U.S. with respect to gender issues and language. African immigrants have gender issues, and their culture proscribes mental health professionals from working with opposite sex. African immigrants had problems with mental health professionals from other cultures, feeling that because of language barriers they were not able to participate in the treatment process. They reported that mental health professionals from the main-stream White culture did not understand the cultural conceptions of mental illness.

The participants' cultural meaning of mental illness characterized these disorders because of suffering from the spirits of the dead, demons, witchcraft, and voodoo. Participants pointed out that mental illness in the U.S. is a health condition involving changes in emotion, thinking and behavior associated with distress and or problems with social functioning and family activities and that this contrast is a source of confusion and distress that adds to the distress of mental health problem. The participants also identified that indigenous cultural stigma associated with mental illness has profound effects on daily life. The experience of stigma was described as negative attitudes of

discrimination with renunciation of needed social resources, no accessibility to affordable housing, child-care, and employment, and the avoidance of help-seeking, and unwillingness to seek treatment, and complete community withdrawal.

RQ3

To appropriately address this question, these two categories were selected to answer the question: Meanings of Help-Seeking and Subject of Story. The participants reported that immigration status and documentation created mistrust and resentment towards American mental health system and were barriers to mental health help-seeking. Participants reported delaying seeking treatment until the problems that could have been treated or prevented became more challenging and difficult to treat. The participants also noted that it would be more advantageous for individuals to work with mental health professionals from their own cultural background who understand traditional treatments and the stigma experienced by those seeking help. Social and economic challenges with strained financial conditions, language barriers and dissimilarities with capabilities were also identified as major impediments to help-seeking.

RQ4

The two categories were relevant and were selected to answer the question: Importance of Cultural Understanding and Dissatisfaction. Participants responded both broadly and specifically to this question. In other words, there was considerable mention of the xenophobia, prejudice, racial discrimination and systemic racism in all aspects of life in the U.S, particularly in parts of the country that were more conservative politically. Chapter 5 will compare the results of the study with the literature review and interpret

and analyze the clinical findings. The theoretical frameworks of segmented assimilation theory and cultural theory of risk will be related to the findings of the study. Limitations of the study will be addressed in addition to recommendations for further studies. Implications for social change at individual, organizational, and national levels will be offered with considerable recommendations for mental health professionals and the psychological science community.

Chapter 5: Discussion

The objective of this IPA was to explore African immigrants' lived experience of mental health, mental illness, and help-seeking. This study contributes to understanding how traditional cultural beliefs held by African immigrants contrast and complicate the meaning of mental health, mental illness, and help-seeking processes that are taken for granted by the non-immigrant public. Nine participants from different countries within the five main regions of Africa described their major mental health, mental illness, and help-seeking experiences to explore the following questions:

RQ1: What is the lived experience of mental health for African immigrants in the U.S.?

RQ2: How does indigenous cultural stigma occur in the meaning of mental illness?

RQ3: How do African immigrants in the U.S. describe their help-seeking experiences?

RQ4: How does indigenous cultural stigma occur in help-seeking?

Rich, thick data was analyzed in two ways. During the first cycle, key content areas were identified from the literature to respond to the research questions. Each of the eight content areas produced three to five dimensions (see Table 1). During the second cycle, I went back to the transcripts, and using a line-by-line analysis of the transcripts, generated eight themes. There were considerable overlaps between these two efforts, with greater depth during the second cycle. In this chapter, I summarize key findings of the study and discuss how they confirm, disconfirm, and broaden published literature.

Limitations, recommendations, implications, and a summary are also included in this chapter.

Interpretation of Findings

Assumptions and Expectations

Participants reported that they came to understand that former assumptions and expectations before migration from their native African countries and on arrival in the U.S. were unrealistic and idealistic. Most participants reported that challenges involving migration and acculturation stress contributed to their mental health problems and need for mental healthcare services and treatments. Renner and Salem (2014) said human values and norms, economic needs, social behaviors, different symptoms of mental illnesses, and approved cultural treatment approaches are embedded with indigenous culture in African collectivist societies that cannot be compared to U.S. individualist societies. Some participants reported that extreme unremitting struggles and frustrations during their attempts to cope with assimilation challenges, systemic racism, cultural discrimination, language dissimilarities, economic impediments, unemployment, disparities in mental health services, and lack of accessibility in terms of effective and acceptable mental healthcare services and treatments triggered their mental problems and need for mental health services and treatments.

African immigrants' traditional cultural belief systems strongly influenced their conceptions of mental health and attitudes towards individuals with mental health problems and their families. It was also found that African immigrants' traditional cultural belief systems influenced notions of mental illness and behaviors towards

individuals with mental health issues and their families. One common response among study participants was that African cultures and immigrants do not accept or trust Western or American developed medical practices, and as an alternative preferred to use traditional healing approaches to treat mental health symptoms.

Most participants did not consider mental health and mental illness as medical problems but believed evil spirits to be contributing factors. These perceptions enhanced the risk of continuing increases in terms of mental health problems. All participants reported that their experiences with assessment and diagnosis processes and modalities of treatments shaped by Western and American hegemonic understandings contrast with their traditional cultural belief systems and practices. Attempts to use conventional mental health systems were not suitable for African immigrants who retained their traditional cultural beliefs.

Importance of Cultural Understanding

African immigrants' cultural vulnerabilities to mental health problems were misunderstood by other cultures. Cultural beliefs influence barriers to reporting mental illness symptoms due to embarrassment linked with the illness. The findings of this study confirmed that there was lack of understanding in terms of how powerful cultural stigmas concerning mental health challenges had been studied among African immigrants. Cultural stigma creates fears that serve as obstructions to professional help-seeking.

Experience of Mental Health

Participants believed in spiritual phenomena as essential to success and physical wellbeing in life, and individuals who died transformed into ascended masters and unseen

ancestral spirits who involved themselves in the affairs of daily living. They serve to generate self-protection from evil forces, good fortune, and success in daily activities, marital success, and protection from mental illnesses. Mental health was a consequence of being in harmonized state with culturally recognized goddesses and spiritual forces that control individuals' abilities to be successful in terms of daily endeavors and physical wellbeing.

Cultural Experience of Mental Illness

Participants reported that mental illness was one of the most misunderstood mental health conditions in African cultures and among African immigrants, and that among most of their native African countries individuals with mental illness are secluded at home by their families for fear of humiliation and embarrassment. Individuals with mental illnesses and their families were stigmatized and discriminated as harmful to the general population. Participants reported that experience of indigenous stigma occurrence in their meaning of mental illness was increased and emboldened by distrust of mental health professionals from other cultures who did not understand their traditional cultural beliefs, language dissimilarities, sociocultural notions of mental illness symptoms, and distrust of psychotherapy and pharmacotherapy.

Meanings of Help-Seeking

The participants described their Help-Seeking Experience in five components of African Experience; U.S. Experience; Cultural Influences; Barriers and Implications; and Traditional Methods of Treatment. Participants soon came to understand that their notions of help-seeking before migration and on arrival in the U.S. were totally

unrealistic and idealistic based on the delivery system of mental health care services and treatments in the U.S. Participants believed that mental health help-seeking created individual distress that was more significant than their real current problem.

African immigrants migrated to the U.S. from a collectivist culture with recognized value systems handed down from generation to generation; and carried around the global communities beyond the borders of African continent by migrants. Individuals from collectivist cultures always failed to conform with mental illness help-seeking possibilities; and collectively circumvent every circumstance connected to disclosing personal information and concerning reporting of experiencing mental illness symptoms. Stigmatization of individuals with mental illness and their families, bring never-ending humiliation to the secured family structures.

This study found that unremitting and unrelenting complications with help-seeking, with willingness and unwillingness to seek treatment for mental health problems were influenced by different negative traditional concepts. The different negative traditional concepts were embedded with traditional cultural belief systems that informed individuals on decision making to seek-help for mental illnesses and to avoid seeking-help with no reasons.

The continuous problems with help-seeking were impacted by mistrust of American mental health system, mental health care services and treatments offered, and dealing the mental health professionals from other cultures. Some participants reported that, the communal living established principles, secured family structures, and friends played significant roles in their help-seeking inclinations. Other participants reported that,

without consulting with conventional mental health professionals, they sought out culturally approved and acceptable traditional treatments to recover from their mental health problems. Several studies have also found that immigrants to the U.S. will still seek culturally familiar sources of support and healing.

Dissatisfaction

The participants described their "Dissatisfaction" in four components of Disparities in Mental Health Services; Racial Prejudice and Discrimination; Accessibility to Mental Health Services; and Assessment and Diagnosis. Participants reported that they came to understand that their notions of dissatisfaction before migration and on arrival in the U.S. were totally unrealistic and idealistic based on the delivery of mental health care services and treatments in the U.S. Stigma made it difficult for individuals to seek-help for mental health problems and mental illnesses.

Participants reported that indigenous cultural stigma prevailed in help-seeking despite their understanding of mental health and mental illness as acceptable medical condition in the U.S. Some participants reported that, indigenous cultural stigma was a major social-calamity that blocked family members understanding to conform with the help-seeking needs of their loved ones diagnosed with mental illness. All participants reported that indigenous cultural stigma was a conceptualized problem brought shame and disgrace from the general population to individuals with mental illness and their families. Some participants reported that, indigenous cultural stigma of mental health help-seeking, vulnerability to systemic racism, and racial discrimination with limited

access to effective mental health care services were obstructions to seeking mental illness treatment.

Subject of Story

The participants described "Subject of Story" in four magnitudes of Mental Health Issues; Mental Illness and Treatment; American Mental Health System; and Social Economic Issues, all of which dispensed clarity to their descriptions of Subject of Story as embedded with their help-seeking experience. Participants reported that they came to understand that their subject of story before migration and on arrival in the U.S. was totally unrealistic and idealistic based on the delivery of mental health care services and treatments in the U.S. Negative attitudes concerning Western/American developed treatments for mental health problems and mental illnesses were influenced by their cultural beliefs systems.

Most participants reported that their help-seeking conditions for mental health problems and mental illnesses were impacted by cultural mistrust of mental health professionals from the main-stream White culture and stigmatization of individuals with mental health problems and their families. Some participants reported that, despite accessible modalities of mental illness treatments, they preferred to contact their family members, traditional native doctors, herbalists, fortune-tellers, spiritualists and faith healers for their help-seeking needs to treat the manifesting symptomatic complications of mental illness.

Most participants reported that they preferred traditional cultural treatments for mental illness to Western/American developed mental illness treatments based on their

understanding of these methods of treatment in their native African countries. Participants reported that the traditional cultural treatments were perceived to be effective and acceptable among African cultures but differed in constituents from the Western/American methods of treatments. Participants reported that accessibility complications, limited accessibility, and no accessibility were major impediments to their help-seeking necessitates. Some participants reported that, they had lower accessibility rating to effective and acceptable mental health care services and treatments. Compared to the main-stream White culture with higher accessibility rating to effective mental health care services and treatments.

Participants reported major inconsistencies in assessments of their mental health care needs and explanations related with utilization of services among. Occurrence of mental health problems that needed treatment differed significantly from the currently recorded information by mental health professionals and researchers. Participants reported that their mental health care needs, and attitudes to seeking mental illness treatment continued to be inappropriately characterized. The main complexity to understanding mental health issues and help-seeking practices of African immigrants was the shortage of correct recorded information of national origin, cultural identity, cultural belief systems, and language differences in the medical care settings literature.

Participant Occupation

The participants described "Participant Occupation" in four magnitudes of Stigma of Mental Illness; Symptomatic Complication; Cultural Perspectives of Mental Illness; and Misunderstanding of Help-Seeking, all of which dispensed clearness to their

descriptions of Participant Occupation, as relevant with occurrence of indigenous stigma in their meaning of mental illness. Participants reported that they came to understand that their notion of participant occupation before migration and on arrival in the U.S. were totally unrealistic and idealistic. As more African immigrants arrived in the U.S. as would their mental health, mental illness, and help-seeking problems increased, that would exacerbate their mental health care services and treatment needs.

All participants reported that their cultural belief systems, collectivists' tendencies, and protected family structures influenced their sensitivities of stigma of mental illness, manifesting symptomatic complications, mental health help-seeking, and the common meaning of mental illnesses. Most participants reported that, traditional values and norms influenced their perceptions of mental illnesses, methods of mental illness treatments, stigmatization of individuals with mental illnesses and their families. Misunderstanding of mental illness symptoms among family members, causative factors of mental illness, and cultural implications created barriers to seeking available mental illness treatments among African immigrants to the U.S.

Participants reported that indigenous cultural stigma was a continuous culturally justified condition embedded with the meaning mental illness that distinguished it from the expectably culturally approved response to a conversant concern which is not considered to be mental illness. Stigma of mental illness and stigmatization of individuals with mental illness and their families created barriers for seeking mental illness treatments despite the established vulnerabilities of individuals with mental illness.

This study determined that Native American Indian population groups abstained from stigmatization of individuals with mental illness, majority within the group, stigmatized selected mental illnesses; others conformed with the established practices that stigmatized all mental illnesses suffered by tribal indigenes. This study also found that by contrast, Asian cultures emphasized on traditional values and compliance with cultural norms, protected family structures, and understanding of expressive self-discipline. Stigmatization of individuals with mental illnesses practiced collectively because mental illnesses are presumed to being conditions of embarrassment and humiliation. Abdulla and Brown (2011) found that irrespective of how other cultures conceptualized mental illness and stigma, African individuals with mental illnesses and their families remained stigmatized because of the deeply embedded cultural belief systems.

Interpreting Findings in the Context of the Theoretical Frameworks

The SAT and CRT were the theoretical frameworks for this study based on the subject matter and population. As described in earlier chapters. segmented assimilation theory recognizes that assimilation to a new culture can take different paths that affect quality of life, support and livelihood (Portes & Zhou, 1993). The participants who were involved with the mental health system were also struggling economically and experienced a path of assimilation that was full of challenges and limited access to resources. So, their mental health condition was made more complex and vulnerable to stigma. These circumstances created more impediments that prevented individuals from seeking mental health care services and treatments (Akresh et al., 2016; Portes & Zhou, 1993).

The cultural theory of risk theory was used to explore the cultural cognitions that influenced mental health, mental illness, and help-seeking attitudes among African immigrants to the U.S. (Douglas & Wildavsky, 1982; Knudtzon, 2013; Shiraev & Levy, 2010). African immigrants whose family members suffered from mental health problems in their native African countries experienced stigmatization of individuals and their families, discrimination, prejudice, embarrassment, humiliation and banishment from their local communities because of cultural presumption of being dangerous. They became opposed to seeking mental health care services in the U.S. for fear that help-seeking in the U.S., would lead to the same conditions that prevailed in their native African countries. This was also apparent when participants described how mental health professionals from other cultures did not understand their cultural beliefs about mental health and illness and were not cognizant of other socialized interactions (e.g., gender issues, use of traditional practices) (Douglas & Wildavsky, 1982). The participants described experiences of utilizing help from family members, ritual practices, mystical power, prayer from their pastors, and spiritual belief systems as social supports and healing (Douglas & Wildavsky, 1982).

Limitations of the Study

This research study has the following limitations. First, it is recognized that discrepant findings and cases were missing because the procedure of snowball sampling kept the sample extremely homogenous. Other areas of the state or country were not sampled. Participation in the research was limited to African immigrants 21 years and older from the Five Main Regions in Africa who spoke English. African immigrant

participants who were younger could have exhibited challenging developmental complications that could have exceeded expectations and the scope of the research. Individuals from other ethnically diverse minority immigrant population groups in the U.S. did not fall within the purview of this research because they were not classified as African immigrants to the U.S. IPA research focuses on selecting cases that represent the phenomenon of interest rather than a heterogenous sample (Smith et al., 2009; (Smith, 2011; Smith et al., 2013), but the current study could suffer from too much homogeneity in responses.

To enhance transferability, the researcher provided a thoroughly defined explanation of the procedures for data gathering, analysis, and interpretation. The researcher described the settings, research design, methodology and the participants with a complete explanation for the information to be transferable to other groups and contexts. The researcher enhanced transferability using rich, description, and another technique for establishing credibility in qualitative research (Shenton, 2006). To enhance dependability, the researcher consulted with methodology and content experts to evaluate the interview and research questions. However, the researcher was the sole interviewer and coder for the analyses. Having additional resources to interview, code and analyze the data would have allowed for triangulation to enhance dependability further. The researcher utilized verbatim transcripts and audio recordings and asked the participants to review the summary of their interview transcriptions as part of the member-checking process; and recorded comments and reflections on all parts of the data collection and

analysis as an audit trail process. These procedures support the credibility of the findings (Shenton, 2006).

Recommendations

The results of the study were limited to a very homogeneous target group of adults immigrating from the five main regions of Africa. Future research could, using the same approach, explore the lived experience of young adult immigrants. These individuals could have a very different world view of cultural assimilation and mental health, and it would be worth understanding their point of view. Another direction could also include immigrants from other parts of Africa or neighboring countries. Future research could also employ research methods where greater triangulation of data sources as well as interviewers could take place. I recommend future researchers to use ethnographic approaches to get a broader assessment of stigma (both indigenous and from the US mental health services), to interview multiple target groups, collect observational data and documents Bengtsson, 2014).

One of most important findings out of this study was the extreme potency of both indigenous stigma and stigma experienced during interactions with the US Mental Health service. Future research is encouraged to study the interaction of these sources of stigma on mental health and illness. Using the themes identified in this study regarding stigma, survey research could be done to assess both and the use of resources and presenting mental health status.

My research findings revealed the issue of economic challenges, but more is needed on the effects of economic challenges African immigrants' on mental health and

help-seeking conditions. Further research can also explore the influence of indigenous cultural stigma of mental illness and treatment among African immigrants with mental illness and their families. Research is also needed to examine the barriers that prevent African immigrants from mental health help-seeking and care provided by mental health professionals from the main-stream White culture.

The findings of this study established that the consequences of indigenous cultural stigma are real, participants lost jobs and their spouses; nobody wants to marry from any family that has a family member who suffers from mental illness. Mental health professionals may not understand how these cultural stigmas influence African immigrant's decision and willingness to seek mental illness treatment. Future studies should interview mental health professionals who work with African immigrant communities, to better understand the obstacles and opportunities for providing better accessibility to effective mental health care services and treatments.

Implications

The results of this study illuminated how different cultural beliefs are experienced in a foreign country, particularly when interacting with established, culturally different processes of managing mental illness and treatment Specifically, the following recommendations are made:

1. Provide appropriate information to the mental health clinicians and researchers concerning possible impediments for African immigrants and instructing them to obtain necessary information from African immigrants

regarding trust about help-seeking for mental health problems and mental illnesses.

2. Encourage recruitment and training of psychologists who understand African immigrants and who come from the same cultural background as African immigrants.
3. Establish community mental health programs (CMHPs) within the community health centers (CHCs) that will offer culturally appropriate information to Africa immigrants concerning mental health, mental illness, help-seeking, recovery, wellness, rehabilitation, and available modalities of treatment.
4. Amalgamate primary health care services and mental health care services, through community public health partnerships for African immigrants.
5. Mental health professionals from other cultures who provide mental health care services and treatments to African immigrants and other ethnically diverse minority immigrant population groups should obtain appropriate rudimentary education on multi-cultural sensitivity and cognizance of African immigrants.
6. Mental health professionals and researchers can be educated in methodologies of constructive communications, meaningful understanding, and attentiveness' to effectively address African immigrants' inimitable mental health, mental illness, and help-seeking necessitates.

Conclusions

In this study, African immigrants to the U.S. referred to immigrants who migrated from the countries within the Main Five Regions of Africa to the U.S. I am the sole researcher in this current study and also an individual of African ancestry and cultural background; so I deeply understand and empathize with the challenges of culturally-influenced conceptions and traditional cultural beliefs concerning experience of mental health, mental illness, and help-seeking with African immigrants (Arzubiaga et al., 2008). I was born and raised at Obot Ndiya, Ikot Ukap, Nsit Ubiom Local Government Area (LGA) in Akwa Ibom State, South-South Region of Nigeria, West Africa, and migrated to Los Angeles, CA, as a foreign student. I have a full understanding of migration and acculturation challenges, language barriers and dissimilarities, prejudice and racial discrimination, social and economic challenges, affordable housing and employment challenges, family and marital problems, mental health, mental illness, and help-seeking problems that African immigrants face in the U.S. My lived experience includes being a foreign student, legalized resident, and naturalized U.S. citizen, and working as a mental health professional with the ethnically diverse minority immigrant population groups that includes African immigrants. This motivated my decision to pursue a Ph.D. in Clinical Psychology and to explore this topic for my dissertation.

The subject matter of the study materialized through the desire to have better understanding of African immigrants' mental health problems, mental illness, and barriers that prevent individuals from seeking accessible mental health care services treatments as other ethnically diverse minority immigrant population groups in the U.S. I

used the double hermeneutic or two-staged interpretation process that involved participants in the study, attempting to make sense of their world lived-experiences while the researcher is trying to make sense of the participants' attempting to make sense of their lived-experiences. The findings from this study enhanced and emboldened the researcher's understanding of the significant challenges experienced by African immigrants who associate mental illness with traditional harmful practices, and others attribute it to evil spirits and blame individuals with mental illness. They come to the U.S. with no change in opinion despite exposure to new sources of information. As an individual of African ancestry and background, the investigator admits that he faced comparable challenges in his earlier year's acculturation and assimilation process in the main-stream culture in the U.S. Understanding that African culture is a way of life for Africans. Their behaviors, their traditional cultural beliefs, values, and symbols that they accept are passed along by communication and simulation from one generation to another generation. African culture is wide-ranging and different from the U.S. culture, expressed in arts and crafts, traditions, religion, music, food, clothing, and languages. The study established that, it is impossible for Africans and African immigrants to desert their traditionally rich culture in totality but, tend to be retaining their culture once in the U.S. Instead of deserting their numerous traditions, they find ways to re-establishing and re-producing themselves through cultural connections cultivated through nationwide association, shared ethnic values, and broad-spectrum objectives.

The findings of this study emphasized the need for better understanding of African immigrants as they navigate through the American mental health system with

their mental health issues, mental illness, and help-seeking impediments comparable to other ethnically diverse minority immigrant population groups in the U.S. African immigrants who participated in this study reported their lived experience with mental health, mental illness, and help-seeking, occurrence of indigenous cultural stigma in mental health, the occurrence of indigenous cultural stigma in mental illness, and the occurrence of indigenous cultural stigma in help-king experience. The researcher anticipates that the findings of this IPA will offer information for better understanding of African immigrants' mental health, mental illness, and help-seeking necessities and prompt the mental health clinicians and researchers to develop and offer effective culturally sensitive and acceptable mental health care services for African immigrants. The researcher hopes that the findings of this IPA will lead to the mental health policy makers' implementation of culturally sensitive mental health policies for African immigrants and other ethnically diverse minority immigrant population groups, based on their traditional cultural beliefs, value systems, norms, language dissimilarities, and notions of mental health, mental illness, and help-seeking necessities.

This research revealed the need of making mental health care services accessible and affordable for African immigrants through culturally appropriate community mental health services. It also revealed the need to offer meaningful services to African immigrants in their local communities which can help alleviate acculturation challenges, social and economic problems, racial discrimination and prejudice, and language dissimilarities which may come from the environment.

The chronological de-humanization, oppression, mistreatment, racial discrimination, prejudice, racial injustice, judicial injustice, high-profile killings of African immigrants, planned high-profile deportation of African immigrants to their native African countries, and aggression against African immigrants has progressed into present day systemic racism, structural barriers to essential mental health resources and benefits, established practices of racism against individuals and families, and cultivated a individually mistrustful and less affluent community experience, characterized by a countless of disparities including insufficient accessibilities to and delivery of care in the American mental health system, mental health care services and treatments. Processing and dealing with layers of individual trauma on top of the current mass traumatic conditions from COVID-19 (improbability, segregation, unhappiness from economic and losses of human lives), police viciousness, multifarious news media complications, and thoughtless opinionated public speaking adds compounding layers of complications for African immigrants as a part of the ethnically diverse minority immigrant population group to conscientiously manage while struggling to better their living conditions in the U.S. needs to be carefully considered and addressed with effective solution for amicable culmination.

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Appendix A: Invitation to Participate in Research

Greetings,

This research is conducted by a doctoral researcher at Walden University, who is conducting a dissertation research to explore the recent mental health, mental illness, and help-seeking experiences of African immigrants to the U.S. Seeking out persons who are fluent in English, have migrated as an adult from one of the countries in the five main regions of Africa, and have personally sought help for mental health issues in the U. S., or have a friend or family member who sought help. The Walden University's Institutional Review Board (IRB) Approval Number for this study is 01-04-19-0170147 and expires on December 17th, 2020.

Interested individuals who meet these criteria are encouraged to participate in a semi-structured, telephone or face- to- face interview lasting approximately for one hour, through which they will share their mental health, mental illness, and help-seeking experiences. All information received from the participants will be recorded and maintained confidentially. The participants may withdraw from the scheduled interview at any time if they so desired and will be offered an opportunity to review the interview transcript summary and the interpretations for accuracy.

The researcher understands that time is essential for everyone and grateful for your thoughtfulness to participate in the proposed research. Interested persons, and those who may know individuals, who would like to be a participant in this study, are free to contact the researcher at their earliest possible time to schedule a date and time for a meeting.

The researcher ’s contact telephone number (XXX-XXX-XXXX), and email, xxxxxxxxxxx.xxxx-xxxxx@xxxxxnu.xxx are enclosed here for convenience. Thanks for kind consideration and support; looking forward to having a response at the earliest possible time.

Respectfully,

Doctoral Researcher,

Appendix B: Consent Form

African Immigrants' Experience of Mental Health, Mental Illness, and Help-Seeking in the U.S.

Walden University, Minneapolis, MN

You are invited to participate in a dissertation research study about how African immigrants with mental health issues – personal, family or friends – seek help in the U. S. You are having been invited to participate because of your understanding and experience connected to the subject matter of the research. The researcher in the proposed research is inviting African immigrants aged 21 years old, who migrated to the U.S. as adults and have lived continuously in the U. S. for a minimum of one year to the date of the study. This form is a component of the process called informed consent. Please read this form carefully and ask all the questions you may have to understand the study before deciding to be or not to be in the study.

Researcher:

The study will be conducted by a doctoral researcher from School of Psychology, Walden University.

Background Information:

The purpose of this study is to explore the meaning of mental health, mental illness, and help-seeking experience among African immigrants to the U.S.

Procedures:

If you agree to be in this study, you will be:

- Requested to participate in one individual face-to-face interview to talk about the meaning of mental health, mental illness, and help-seeking experiences.
- This will last from 45 to 60 minutes.
- . After the interview is completed and transcribed, requested to review the summary of your interview to ensure the researcher has an accurate representation of your view. This would take about 15 minutes.

Here are some sample questions:

- Tell me more about your help-seeking experience?
- How did you feel about this experience?
- How informed were the mental health clinicians about your culture?
- How informed were the mental health clinicians about your understanding of your problem?
- How did they explain your problem? Your treatment?
- How much were they able to help?

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether you choose to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of minor discomforts that can be encountered in daily life, such as exhaustion, nervous tension, becoming aggravated and unpleasant memories. Being in the proposed study will not pose a risk to your safety or wellbeing. A current list of Los Angeles City Mental and Behavioral Health and Psychiatric Emergency Care is included in this form for you to contact should you experience distress during or after the interview.

The research findings will contribute to a better understanding of help-seeking for mental health issues for African immigrants and can be used to improve access to services. After the study is completed, you will be sent a summary of the findings.

Payment:

Participation is voluntary**.** The $5.00 gift card will be provided prior to conducting the interview to clarify that it is a token of appreciation

Privacy:

Any information you will provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this proposed research project. Also, the researcher will not include your name or anything else that could identify you in the research reports. As a mandated reporter of child abuse and abandonment, the researcher will comply with the mandated reporter laws as stipulated by the State of California during the study.

Data will be kept secure by password-protected computerized systems and locked cabinets. Data will be kept for at least five years, as required by the Walden University.

Contacts and Questions:

You may ask any questions you have now. Alternatively, if you have questions later, you may contact the researcher via my phone number (XXX) XXX-XXXX and email address xxxxxxxxxxx.xxxx-xxxxx@waldenu.edu. If want to talk privately concerning your rights as a participant; you can call the Walden University representative who can discuss this with you and answer all of your questions. The phone number is (XXX) XXX-XXXX. Walden University's approval number for this study is **01-04-19-0170147, and it expires on December 17th, 2020**. Please print or save this Consent Form for your records.

Statement of Consent:

I have read the above information, and I feel I understand the proposed research well enough to decide my involvement. I have asked questions and obtained appropriate answers. By replying to this email with the words, **"I consent,"** I understand that I agree to the terms described above.

Appendix C: Interview Guide

Date: ----------

Location: ----------

Name of Interviewer: ----------

Name of Interviewee: ----------

Interview Questions

1. Tell me about a time when you had to interact with the American Mental Health system?
    a. Who was it for? (self, family, friend)
    b. Tell me what happened? (Was there an event, a problem……?)
    c. How did you know this was a mental health issue?
        i. Did you seek help?
        ii. How did you find help?
    d. What happened after that?
    e. How did you handle this experience?
    f. What did this experience mean to you? (How did you feel about yourself as you were going through this?)
    g. How did your family and friends respond to what happened?
2. Tell me more about your help-seeking experience?
    a. How did you feel about this experience?

    I. How informed were the mental health clinicians about your culture?

ii. How informed were the mental health clinicians about your understanding of your problem?

iii. How did they explain your problem? Your treatment?

iv. How much were they able to help?

v. How did their approach meet your understanding of your problem?

1. If you were in your native country, how would your problem be described?
2. How would your problem be treated?

b. How did your family and friends feel about your help-seeking?

3. How would this have been if this had happened in your native country?
   a. How was this experience different than what you would have experienced in your native country? What would have been different?
   b. How would your family and friends have reacted if this happened in your native country?
4. How would you describe what mental health means in the U.S.?
   a. How this is different than what mental health means in your native country?

1. In closing, is there anything else you would like to describe that would help me understand your experience?

Appendix D: Mental Health Resources

Los Angeles, CA, U.S.

1. Los County Mental Health Department (LACMHD)

   Crisis Counseling

   800-854-7771 /7 ACCESS)

   800-854-7772

2. Exodus Recovery

   Mental Health Urgent Care

   323-276-6400

   1920 Marengo Street, LA, CA 90023

3. Domestic Violence

   Center for the Pacific Asian Family

   800-339-3940

   1102 Crenshaw Blvd.,

   Los Angeles, CA 90019

4. Abuse Hotline - Child Protection Hotline

800-540-40000

1102 Crenshaw Blvd.,

Los Angeles, CA 90019

5. Dependent Adult Abuse Hotline

   800-992-1660

6. Elder Abuse Hotline:

   877-477-3646

7. California Suicide & Crisis Hotlines

   Los Angeles County Department of Mental Health: Hotline

   (24 Hours/7Days)

   Tel: 1-800-854-7771

8. National Suicide Prevention Hotlines

   Toll-Free / 24 Hours / Days a Week

   1-800-SUICIDE / 1-800-784-2433

   1-800-273-TALK / 1-800273-8255

   TTY: 1-800-799-4TTY (4889).

Appendix E: Transcriptionist Confidentiality Agreement

Name of Signer:

During my action in transcribing data for the Proposed research: "African immigrants' Perspectives on Mental Illness and Treatment in the United States," I will have access to information, which is confidential and should not be make known. I recognize that the information must remain confidential and that improper disclosure of confidential information in the proposed research will be damaging to the participants.

By signing this "Confidentiality Agreement," I acknowledge and agree that:

1. I will not reveal or discuss any confidential information with others, together with friends or family members.
2. I will not in any way make known, copy, release, sell, loan, change or destroy any confidential information except as appropriately given permission.
3. I will not communicate confidential information where others may overhear the discussion. I recognize that it is not tolerable to discuss confidential information even if the participant's name is not used.
4. I will not create any unauthorized transmissions, investigations, adjustment or exclusion of confidential information.
5. I consent that my commitments under this conformity will extend after the termination of the work that I will implement.

6. I recognize that any breach of this agreement will have serious legal repercussions.
7. I will only entrance or utilize systems or devices which I am officially permitted to access, and I will not reveal the operation of a function of systems or devices to not permitted individuals.

Signing this Document, I recognize that I have the agreement and I agree to comply with the circumstances and provisions confirmed above. I am fully aware that I may be held lawfully responsible for any violation of this "Confidentiality Agreement," and for any harm sustained by the individual participants' if I reveal identifiable information contained in the audiotapes and files to which I will have access.

Transcriptionist's Name (printed) ----------

Transcriptionist's Signature ----------

Date: _____

Appendix F: NVivo Code Book of Research Data

Codes and Categories

Categories are designated in bold, followed by codes.

Assumptions and Expectations – African immigrants' perception; immigrant population groups; mental health; mental health care service utilization rates; mental health clinicians; mental health clinics; mental health condition; mental health disorders; mental health issues; mental health needs; mental health professionals; mental health services; mental health system conception; mental health treatment centers; mental health problems; and disorders.

Importance of Cultural Understanding – African cultures have many misconceptions concerning mental illness; African cultures attitude concerning mental illness is negative; public stigma is the reaction that the general population has to people with mental illness; it is perceived that concerning causes of stigma a strikingly; my understanding of stigmatization of individuals with mental illness; structural or established practice discrimination includes the policies; after more fully assessing intentional and unintentional forms of structure; African immigrants experience implications of ongoing discrimination; among African immigrants to the U.S. there is no change in opinion of discrimination; discrimination and prejudice faced by individuals who have mental illness; stigma involves negative and demeaning views concerning individuals with mental illness and their families; the most harmful effects of stigma of mental illness among African immigrants; the culture of stigma and discrimination fueled by poor awareness allocated to mental illness; African cultural beliefs and values of collective

help give dignity to individuals with mental illness; and there is a widespread believes linking mental illness to supernatural philosophies.

Experience of Mental Health – Mental health is commonly utilized for mental illness; mental health is a state of wellbeing in which individual realizes his or her full potentials; understanding is that some African immigrants are estimated to be among; African immigrants recognized that American mental health care system; African immigrants believe that mental health problems and mental illness; African immigrants also have high expectations concerning mental health system; African immigrants disbelieve that American mental health system; African immigrants do not recognize indicators of mental health; mental health is a neglected condition, there is need for organization; although mental health refers to beliefs and notions of ethnically diverse minority individuals; my lived experience and understanding of mental health; and there should be a commitment by African cultures and African immigrants concerning mental health.

Cultural Experience of Mental Illness – African cultures have many misconceptions concerning mental illness; most of the time you will hear Africans say that individuals with mental illness are crazy; when individuals have mental illness their family keep them in the house; their relatives reject some individuals with mental illness because of the disgrace; mental illness among African immigrants refers to collectively all diagnosable metal disorders; African cultures and African immigrants do not believe that mental illnesses are medical conditions; mental illness is one of the leading causes of mortality and morbidity in African cultures; mental illness in my native African country made individuals miserable; mental illness symptoms can affect emotions, thoughts, and

behaviors; distressing symptoms exacerbated by inability to participate in work; and mental illness refers to a wide range of mental health conditions.

Meanings of Help-Seeking – There are no community mental health treatment centers; African immigrants have lower rates of utilization of mental health services; mental health care treatment services and treatments are available for the ethnically diverse; generally, mental health care services utilization rates vary by nativity; mood and anxiety disorders carry a significant human and social burden; African immigrants expect to be cared for by medical doctors or psychologists; African immigrants feel that when mental health clinicians do not understand; if a family member exhibits symptoms that Western medical professional; and my lived experience description that currently describes the relation.

Dissatisfaction – Discrimination; cultural discrimination; ongoing discrimination; practice of discrimination; racial discrimination; structural discrimination; stigmatized health conditions; mental health needs; mental health condition; beliefs; cultural beliefs; traditional beliefs; and widespread belief.

Subject of Story – Who the participant is referring to in the experience of mental health; AMHS does not build relationships with immigrant groups; someone I know; there is assumption of disparity; notion that African immigrants will not be given good treatment at community mental health clinics; negative remorse and bad news which are made known through the whole African immigrant's community; Africans cultural beliefs about mental; African immigrants believe that depression is their most common type of mental illness; African immigrants disbelieve that American mental health system in the

mental health and the public health arena put more importance; and they feel that little has been done by American mental health system.

Participant Occupation – Working in hospital legal department; immigrants; mental illness after childbirth; economic conditions; services; health condition; involving health conditions, anxiety disorder; bipolar disorder; eating disorders; medical disorders; mental disorders; and mental health disorders.

Appendix G: Recognized Main Five Regions in Africa

1. North Africa: (Made up of Six Countries)

Egypt

Libya

Tunisia

Algeria

Morocco

Western Sahara

2. West Africa: (Made up of Eighteen Countries)

Benin

Burkina Faso

Cameroon

Cape Verde

Chad

Côte d'Ivoire

Gambia

Ghana

Guinea

Guinea-Bissau

Liberia

Mali

Mauritania

Niger

Nigeria

Senegal

Sierra Leone

Togo.

3. Central Africa: (Made up of Six Countries)

Central African Republic

Congo

Democratic Republic of Congo

Equatorial Guinea

Gabon

São Tomé and Príncipe

4. East Africa: (Made Up of Fourteen Countries in the Horn)

Eritrea

Ethiopia

Somalia

Djibouti

Sudan

Uganda

Kenya

Tanzania

Rwanda

Burundi

Comoros Island

Mauritius Island

Seychelles Island

Madagascar Island

5. Southern Africa: (Made up of Ten Countries)

Angola

Botswana

Lesotho

Malawi

Mozambique

Namibia

Southern Africa

Swaziland

Zambia

Zimbabwe

Appendix H: United Nations Map of Five Main Regions in Africa