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East African Immigrants' Perceptions of Mental Illness in the United States

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Abstract

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MS, Walden University, 2019

MBA, Coleman University, 2013

BS, Makerere University, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Mental illness is considered a silent killer in East Africa as it affects 1 in 4 people. Differences exist in how individuals from Western countries perceive mental illness compared to East Africans' perceptions. The purpose of this qualitative study was to understand the lived experiences of East African immigrants to the United States and the impact of these experiences on their perceptions of mental illness. Social learning theory and Berry's acculturation model provided the framework for the study. Data were collected from 12 semistructured individual interviews with participants 20 years and older. The three themes that emerged from coding analysis were (a) perceptions of mental illness, (b) treatment of mental illness, and (c) destigmatizing mental illness. The findings indicated that mental illness stigma continues to be one of the barriers in accessing mental health services. The findings also indicated that East African immigrants in the United States often change their perception of mental illness because of the education, acceptance, and accessibility associated with mental illness in the United States. The results may be used to improve mental health services for East African immigrants in the United States and to improve the cultural competency of mental health providers when treating East Africans in the United States. The results may also contribute to improving mental health services in East Africa when shared with organizations such as the World Health Organization, Alliance for African Assistance, and International Rescue Committee leading to positive social change.

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Dedication

My doctoral study is dedicated first and foremost to my God, who continues to fight my battles and makes me victorious in every challenge that I face. Thank you for watching over me and blessing me with a good life, great family and friends, faith, love, and humility. Without you, I would not have made it this far.

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Table of Contents

List of Tables

Chapter 1: Introduction to the Study

The current study was designed to understand the lived experiences of East African immigrants in the United States and their perceptions of mental illness. As East Africans migrate to the United States, they come with their perceptions, beliefs, and cultural practices that surround mental illness that often vary from those in the United States (Omenka et al., 2020). As East African immigrants begin to settle and navigate the new environment, social learning and acculturation begin. As East African immigrants are exposed to various experiences and environments, some of their existing perceptions, beliefs, and cultural practices may begin to shift to imitate those of the new environment (Omenka et al., 2020). I aimed to understand the experiences that lead to a change in perceptions of mental illness. This chapter provides background information on the cultural norms surrounding mental illness in East Africa and how these norms affect individuals with mental illness as well as the overall communities in which the individual lives. The research questions that guided the study are also stated, as is the nature of study, theoretical foundation, significance, and limitations of the study.

Background

East Africa is made up of several developing countries, including Burundi, Djibouti, Ethiopia, Kenya, Rwanda, Somalia, Southern Sudan, Tanzania, and Uganda, that have a different perception on mental illnesses and treatment compared to the Western world. Mental illness continues to be considered a taboo, and individuals who suffer from it are stigmatized and often shunned from society or kept in isolation (Hanlon et al., 2010). Individuals with mental illness are often ignored and blamed for their

mental illness and are therefore not provided with the proper treatment (Hanlon et al., 2010). When they do get treatment, it is often from traditional healers because mental illnesses are often associated with evil and other ancestral spirits (Atilola, 2016).

According to Bailey (2014), the hindrances to the development and delivery of improved mental health services in Uganda include the shortage of mental health professionals and inadequate training of the few who are available. For example, nurses who are employed to work in psychiatric hospitals do not have mental health classes in their school syllabus (Bailey, 2014). Additionally, lack of education on awareness and acceptance of mental health services as well as the negative effects of mental illness stigma and discrimination against individuals with mental illness continues to increase the negative perceptions of mental illness (Bailey, 2014). According to Corrigan et al. (2014), in East Africa individuals with mental illness avoid acknowledging that they have a mental illness due to the stigma that is associated with a mental illness diagnosis. This stigma is often received from friends, employers, family, religious leaders, and service providers, such as health professionals (Corrigan et al., 2014). The stigma that the individuals with mental illness face leads to decision making that can be harmful to the individual, such as socially withdrawing, avoiding certain careers, and suicide (Corrigan et al., 2014).

According to Kopinak (2015), a weak referral system, shortage of skilled staff, inaccessibility, and shortage of pharmaceuticals pose challenges to the mental health system in many East African countries. Despite the challenges, there are ways to improve mental health services in East Africa, such as acknowledgment by the governments on

the prevalence of mental illnesses and the urgent need for services to take care of their citizens (Knettel et al., 2018). Sharing with individuals the positive results of Western approaches in the treatment of mental illness can also increase the acceptance of the approaches by the local community (Knettel et al., 2018). For example, positive results have been seen from the use of interpersonal psychotherapy to treat depression in two districts in Uganda (Lewandowski et al., 2016). Some of the results reported by the patients included an increase in school attendance, increased productivity in agriculture, improved sanitation, and decreased family conflict (Lewandowski et al., 2016).

East African countries continue to face challenges such as competing priorities, low community engagement, relying on community volunteers rather than skilled staff, low funding, and inconsistent supplies of psychotropic medication in the implementation of mental health systems and the provision of proper mental health services (Hanlon et al., 2010). However, increasing the quality and sustainability of mental health in primary care through adequate supervision, ongoing training, creating reliable referral networks, developing robust mechanisms to ensure reliable supplies of psychotropic medications, and supporting the provision of simple and feasible psychosocial interventions to expand medication approaches in the time-pressed primary care setting can help in the improvement of existing mental health systems and in the implementation of new ones (Hanlon et al., 2010). Increasing mental health services may help reduce the stigma on mental illnesses as more of the population accessing mental health services could provide a sense of normalcy in receiving treatment for mental illness (Hanlon et al., 2010). Additionally, interpersonal psychotherapy was reported as an effective program, and the

communities in which it was used suggested that the program be expanded to other communities where depression and post-traumatic stress disorder are high (Lewandowski et al., 2016). This indicated that there is hope for the acceptability of mental illness and mental health treatment.

With exposure and education, many East African immigrants are beginning to see mental illness in a different way than what they were told growing up (Kopinak, 2015). East African immigrants have the chance to see that individuals with mental illnesses can live long, fulfilling lives and become influential members of society and not just destructive and burdensome as they are made to appear in East Africa (Kopinak, 2015). There is a significant change in how East African immigrants now view mental illness. Many of them work in the social services field as direct support professionals, nurses, doctors, social workers, case managers, caregivers, and other mental health professionals (Elo et al., 2015). Additionally, many East African immigrants use mental health services either for themselves or as a support person for a loved one and are therefore more empathetic to individuals with mental illness (Elo et al., 2015). The current study addressed the acceptance and understanding of East African immigrants and how it occurs through contributing bridging concepts between global standards of care and local cultural and spiritual perspectives as described by Monteiro (2015).

Problem Statement

Understanding perspectives of East Africans regarding mental illness who have immigrated to Western countries is often difficult for people in those societies (Shipp et al., 2014). Mental illness continues to be considered a taboo in East Africa, and

individuals who suffer from mental illness are often stigmatized and shunned from society or kept in isolation (Hanlon et al., 2010). Additionally, individuals with mental illness are often ignored and blamed for their mental illness and are consequently not provided proper treatment (Atiloa, 2016). When they do get treatment, it is often from traditional healers because mental illnesses are commonly associated with evil and ancestral spirits and other myths and beliefs such as witchcraft or punishment for promiscuity (Atilola, 2016).

As a result of mental illness stigma, many mental illnesses such as anxiety and depression go untreated leading to severe psychological disorders such as major depressive disorder and social anxiety that negatively affect the individual's overall well-being and quality of life (Ngui et al., 2010). An individual's psychological well-being is linked to many aspects of their lives such as success in school, work, and relationships; therefore, stigma and discrimination against mental illness may hinder their ability to accesses mental health treatment, thereby affecting their ability to succeed in those areas (Elo et al., 2015). Mental illness stigma and deprivation of mental health treatment has also been linked to social dysfunction and premature death (Ebuenyi et al., 2019).

Purpose of the Study

The purpose of this study was to understand the lived experiences of East African immigrants in the United States and the impact of these experiences on the East African immigrants' perceptions of mental illness. East Africa is made up of several developing countries, including Burundi, Kenya, Rwanda, Tanzania, and Uganda. Each of these countries has a different perception of mental illnesses and treatment, all of which differ

from Western perceptions (Amuyunzu-Nyamongo, 2013). Differences exist in how individuals from Western countries perceive mental illness compared to East Africans' perceptions (Amuyunzu-Nyamongo, 2013). Perceptions vary in diagnosis, treatment, and overall acceptance by the community. The current study was conducted with individuals who were born and raised in East Africa and migrated to the United States as adults.

Research Questions

I sought to answer two research questions (RQs):

RQ1: What are the lived experiences of East African immigrants in the United States in relation to mental illness?

RQ2: How do East African immigrants to the United States describe their perceptions of mental illness in East Africa in comparison to the United States?

Theoretical Framework

This study was guided by Bandura's (1997) social learning theory and Berry's (2007) acculturation model. Social learning theory provides an understanding of how individuals learn behavior (Bandura, 1997), and Berry's model of acculturation provides an understanding of acculturation strategies that individuals use to navigate a new culture. Because I aimed to understand the lived experiences of East African immigrants in the United States and how they contribute to their perceptions of mental illness, social learning theory and Berry's acculturation model were appropriate theoretical frameworks for the study. The two theories were used to understand the learning process as it relates to mental illness stigma, specifically what learning models and acculturation strategies contributed to changes in perception and behavior following immigration.

East Africans who migrate to the United States come here with behavior, thoughts, and perceptions on mental illness that they have learned throughout their lives that may not fit with the U.S. mental health culture. One way East African immigrants can resolve this conflict in culture and navigate the differences is by learning from their new peers, colleagues, and community members through observation and retention. Observing how families and communities in the United States treat those with mental illness and seeing it over and over could influence the immigrant's perceptions of mental illness. One example is witnessing more acceptance and inclusion in society of individuals with mental illnesses than is often the case in East Africa. This fits with the social learning theory, which indicates that learning occurs through imitating those around us (see Bandura, 1997). However, this can also be explained by the assimilation strategy, a concept that is part of Berry's (2007) acculturation model.

Nature of the Study

I used a qualitative approach. Data were collected through 12 individual semistructured interviews and two focus group discussions, each with six participants from at least three East African countries. Some of the questions that were used in the focus group discussions included "What are the social-cultural beliefs about mental illness in the participants' countries of origin?" "What are the social consequences of having a mental illness?" and "What are the effects of said consequences to the individual and community?" Some of the individual interview questions included "What was the participant's perception of mental illness while in East Africa?" "What is the participant's

perceptions of mental illness since moving to the United States?" and "What experiences contributed to these perceptions?"

The study's design was phenomenological because I focused on understanding the experiences of East African immigrants who have used mental health services in the United States. The participants were recruited through flyers posted on different resource boards in schools, community agencies, and Facebook groups such as Ugandan North American Association, Kenyans/Americans in the United States of America, and United Women of East Africa Support Team. These groups are made up of thousands of members who have lived in the United States and East Africa and were therefore able to provide relevant data to answer the research questions. Snowball sampling was also used.

Definitions

The following terms were relevant to the study. Therefore, this section provides definitions that were used for clarity and understanding of each term.

Acculturation: The extent to which individuals recognize cohesions among the dominant culture or among their culture and group of origin (Berry, 2007).

Assimilation: The imperceptible process by which immigrant individuals enter social positions and acquire educational, economic, and political standards of the dominant culture and become integrated within these standards while replacing those of their native culture (Berry, 2007).

Beliefs: Ideas that help to influence behaviors that are not universally accepted but vary in individuals or from place to place (Vargas & Wilson, 2012).

Cultural interaction: The intercommunication and social involvement of individuals who share differences in cultural practices and norms (Berry, 2007).

Culture: Characteristics and knowledge of a particular group of people (Vargas & Wilson, 2012).

Discrimination: Unfairness as well as inequality in treatment of a people (Vargas & Wilson, 2012).

Dominant culture: People from the mainstream or host culture or community (Berry, 2007).

East African immigrants: Individuals who were born in the eastern region of Africa and migrated to the United States.

East Africans: Citizens of any country in the eastern part of Africa such as Ethiopia, Somalia, Southern Sudan, Tanzania, Kenya, Uganda, Mozambique, Djibouti, Rwanda, Burundi, Comoros, Malawi, Zambia, Zimbabwe, and Madagascar.

Ethnicity: Values, cultural heritage, and traditions shared by a group of people (Vargas & Wilson, 2012).

Immigrant: A person who has citizenship in another country and moves to a new country with the intent to establish permanent residency (Office of the UN Special Advisor on the Prevention of Genocide, 2016).

Immigration: Relocation from one territory to another, which can be voluntary or by force (Office of the UN Special Advisor on the Prevention of Genocide, 2016).

Integration: Preserving the values, customs, and beliefs of the original culture while adapting the values, customs, and beliefs of a host community (Berry, 2007).

Marginalization: Immigrants refusing to be identified with their own culture as well as the host culture (Berry, 2007).

Mental illness stigma: The negative attitude toward a person who has a mental illness (American Psychological Association, 2012).

Nondominant culture: Those considered from a minority ethnic cultural orientation (Berry, 2007).

Perception: A belief or opinion often held by many people and based on how things seem (Vargas & Wilson, 2012).

Phenomenology: A method used to describe phenomena through lived human experiences (Ravitch & Carl, 2016).

Separation: Immigrants deciding to reject the customs and culture of mainstream society and remain segregated (Berry, 2007).

Stereotype: Social and cognitive beliefs about a cultural group that can either positively or negatively affect behaviors and attitudes toward the group members (Vargas & Wilson, 2012).

Values: Ideals such as achievement, education, language use, and religious identity that are maintained through tradition (Vargas & Wilson, 2012).

Assumptions

The goal of this phenomenological study was to describe the lived experiences of East African immigrants and the impact of these experiences on mental illness perception through the eyes of individuals who comprehend the issue. Eligible participants were East Africans over the age of 20 who migrated to the United States as an adult and had

lived in the United States for at least 2 consecutive years since migrating. The first assumption was that each participant was an East African immigrant to the United States. The second assumption was that each participant had an experience related to mental illness. The third assumption was that each participant had different perceptions of mental illness based on their experiences in East Africa and the United States. A fourth assumption was that the participants were truthful in their responses to the interview questions.

Scope and Delimitations

This study was confined to the lived experiences of East African immigrants over the age of 20 living in the United States and their perceptions of mental illness. Participants were recruited through purposeful sampling to ensure that they met the criteria for participation. Data were collected through individual interviews and focus group discussions. The study was grounded by the social learning theory (Bandura, 1997) and Berry's (2007) acculturation model. The study excluded African immigrants who were not from East African countries, East Africans who migrated to the United States before the age of 18, and first-generation Americans. To ensure transferability, several methods were used in participant selection to access various participant pools.

Limitations

One limitation of the study was that the results cannot be generalized to all East African immigrants in the United States because individual experiences vary as people often interpret things based on their worldviews. Another limitation was that the study did not include controls for socioeconomic factors, gender, family background, religion,

and level of education as criteria in participant selection, although previous studies showed that demographic factors could be a predictor of increased mental illness stigma. Finally, East African immigrants without access to the internet, those who were not in school, or those who did not eat out frequently may have missed the call to participate in the study. Transferability may have also been difficult to achieve in case the participants' experiences were too similar despite the variations in participant selection.

Significance

Understanding experiences of mental illness as expressed by East African immigrants to the United States may lead to improved mental health treatment and services in East Africa and among East African immigrants who struggle to seek help for mental illnesses. This study may help inform how mental health services in the United States are catered to fit the needs and cultural practices of East African immigrants. Additionally, results from this study could aid in understanding what aspects of the U.S. mental health system provide positive or negative experiences for East African immigrants and how those experiences contribute to their perceptions of mental illness. This study may contribute to the implementation of future mental health programs in East Africa, as well as to a generally positive change in the perception of mental illness. The study may also be beneficial to social change in East African countries by promoting the use of mental health services, thereby leading to a healthier society. This may be achieved when the results of the study are shared with organizations that provide mental health services to East Africans in both the United States and East Africa, including the

Alliance for African Assistance, World Health Organization, and International Rescue Mission and World Vision.

Summary

This chapter introduced the study by providing background on the mental health systems in East African countries as well as the cultural context about mental illness, including mental illness stigma toward individuals with mental illness and the negative consequences of mental illness stigma. The chapter also introduced the theoretical frameworks on which the study was grounded and why they were chosen for the study. Research questions guided the study were presented as well. Also discussed in the chapter was the nature of the study. Chapter 2 provides an in-depth literature review and detailed information about the theoretical frameworks and the cultural, social, and religious perspectives of mental illness in East Africa.

Chapter 2: Literature Review

Mental illness continues to be considered a taboo in East Africa with individuals who suffer from mental illness often heavily stigmatized and shunned from society or kept in isolation (Hanlon et al., 2010). Additionally, individuals with mental illness are often ignored and blamed for their mental illness and are consequently not provided proper treatment (Atilola, 2016). When they do get treatment, it is often from traditional healers because mental illnesses are commonly associated with evil and ancestral spirits and other myths and beliefs such as witchcraft or punishment for promiscuity (Atilola, 2016). According to Amuyunzu-Nyamongo (2013), the term “depression” is not culturally acceptable in Uganda, and people respond with fear, anger, and avoidance toward those who are presumed to have mental illness. The purpose of the current study was to understand the lived experiences of East African immigrants in the United States in relation to their perception of mental illness.

As the number of East African immigrants to the United States increases, so does exposure to different social, cultural, and religious perspectives on mental illness. With exposure and education, many East African immigrants in the United States are beginning to view mental illness in a different way from the social, cultural, and religious perspectives of East Africa (Kopinak, 2015). East African immigrants in the United States are exposed to the concept that individuals with mental illnesses can have long, fulfilling lives and become influential members of society, rather than being only destructive and burdensome as they are portrayed in East Africa (Kopinak, 2015). There is a significant difference in how East African immigrants in the United States perceive

mental illness and individuals with mental illness. According to Elo et al. (2015), many East African immigrants in the United States work in the social services field as direct support professionals, nurses, doctors, social workers, case managers, caregivers, and other mental health professionals where the treatment of individuals with mental illness varies significantly from East Africa. Additionally, there has been an increase in how many East African immigrants in the United States use mental health services either for themselves or for a loved one, and these immigrants are more empathetic to individuals with mental illness (Elo et al., 2015). Understanding the experiences East African immigrants to the United States go through to get to this place of acceptance and understanding could be beneficial in promoting a healthier mental health culture in East Africa (Monteiro, 2015).

This chapter includes the literature search strategies, literature review, and underpinning theory. The literature search strategies indicate the methods used to retrieve literature related to mental illness stigma in East Africa; cultural, social, and religious perspectives of mental illness in East Africa; and the overall causes of mental illness stigma. The theoretical foundations for this study, Bandura's (1977) social learning theory and Berry's (1994, 2001) model of acculturation are also described. This chapter also includes a discussion of the entrance of East African immigrants to the United States. Further discussion includes the prevalence of mental illness in East Africa and the social, cultural, and religious perspectives of mental illness in the United States. The chapter ends with a summary and conclusion.

Literature Search Strategy

Information used to conduct this review was retrieved from the Walden University library, government databases such as the U.S. Census Bureau and the Migration Policy Institute, local libraries in San Diego, Google Scholar, and other organization and government websites such as the World Health Organization, Unite for Sight, Alliance for African Assistance, International Rescue Committee, United Women of East Africa, and the National Institute of Mental Health. Additional information was retrieved from databases such SAGE Journals, ProQuest Central, Thoreau multiple databases, multidisciplinary databases in EBSCOhost, and Science Direct that were accessed through the Walden University library. Additional resources included psychology databases simultaneous search and Dissertations and Theses databases at the Walden University library, as well as libraries from other universities. A comprehensive search was conducted from the various databases by typing specific words into the search boxes and setting the date of publications between 2010 and 2020 for the most current research. Some of the search words included *mental illness, mental health, perceptions, stigma reduction, East Africa, immigrants, traditional healers, acculturation, global mental health, culture, religion, mental illness stigma, causes of stigma, mental illness culture in Africa,* and *mental illness culture in the United States*. Information on mental illness in East Africa was obtained by searching the World Health Organization's database and obtaining statistics on the prevalence of mental illness as well as the cultural norms and practices surrounding the treatment of mental illness. Several phrases such as *mental illness stigma in East Africa* and *cultural, social, and religious perspectives of*

mental illness in East Africa were searched in Google scholar to obtain recent articles that addressed the topic of mental illness in East Africa.

Theoretical Foundation

This study was theoretically guided by Bandura's (1997) social learning theory and Berry's (2007) acculturation model. Social learning theory provides an understanding of how individuals learn behavior, which aligned with the purpose of this study. Additionally, Berry's model of acculturation provides an understanding of acculturation strategies that individuals use to navigate a new culture. Because I aimed to understand the lived experiences of East African immigrants in the United States and how these contributed to their perceptions of mental illness, social learning theory and Berry's acculturation model were good frameworks for the study. The two theories were used to understand the learning process as it relates to mental illness stigma, and specifically what learning models and acculturation strategies contributed to any changes in perception and behavior.

Social Learning Theory

Social learning theory, which was established by Bandura (1977), was one of the frameworks used to understand any differences in the perceptions of East African immigrants to the United States on mental illness. Social learning theory emphasizes the notion that people learn through observing and modeling other people's behavior, attitudes, and the consequences of the behavior and attitudes (Nabavi, 2012). Social learning theory directed the research questions to understand any changes in East African immigrants' behaviors and attitudes toward individuals with mental illness by providing

information on how learning occurred. Social learning theory is based two main concepts: observational learning and the modeling process.

Observational Learning

According to Bandura (1977), in observational learning people learn through watching another person carry out the behavior as portrayed in the experiment of the Bobo doll. In the Bobo doll experiment, children watched an adult act aggressively toward a Bobo doll; the children imitated the aggressive behavior that had been observed from the adult (Bandura, 1977). Three models of observational learning were identified by (Bandura 1977, as cited in Nabavi, 2012): a live model, a verbal instruction model, and a symbolic model.

In the live model, a real person is used to perform the behavior in view of the observer, such as in the Bobo doll experiment (Nabavi, 2012). This can also include students watching a teacher or athletes watching their coach or peers. In the verbal instruction model, the behavior to be learned is described with as many details as possible for the observer (Nabavi, 2012). This can include listening to someone read a recipe on how to prepare a meal or a manual on how to change a tire. In the figurative or symbolic model, an actual or fictitious character shows the actions via television, films, broadcasting, YouTube, books, and other channels (Nabavi, 2012). This can include the many makeup artists on YouTube and Instagram who show their viewers how to wear makeup or how to braid their hair.

Additionally, Bandura (1977) indicated that a person's mental state is vital to learning. Bandura argued that in addition to external reinforcement to learning, intrinsic

reinforcement is also crucial to learning. That is, how an individual feels after performing the observed behavior can influence whether they continue to perform it or whether they stop (Nabavi, 2012). Bandura indicated that this is often a form of internal reward such as feeling accomplished or good after performing the behavior. Despite all the models of observational learning and the mental state, Bandura emphasized that learning does not guarantee a change in behavior.

Modeling Process

Because people do not always learn observed behavior, the modeling process helps increase the probability that social learning is successful (Bandura, 1977). Therefore, in addition to observation, four other steps must occur through the modeling process: attention, retention, reproduction, and motivation (Bandura, 1977). During attention, the person learning must pay attention because any distraction will impact the quantity and quality of what is learned (Bandura, 1977). When a person gives their full attention, more learning is expected to occur (Bandura, 1977). This is even more likely when the model of teaching is interesting or when the person modeling is liked (Nabavi, 2012). This explains why some television advertisements are more effective than others and why sports companies use the best athletes as brand ambassadors for their items.

Retention involves the ability to save the learned information and retrieve it for use at a later time (Bandura, 1977). Retention is crucial because without it, a person might need to observe the model again so they can repeat the behavior (Nabavi, 2012). Individuals who observe a behavior and are interested in it will often develop strategies to

retain everything they have observed for easier application in the future because without retention, learning may not be established (Nabavi, 2012).

After attention and retention occur, reproduction follows. Reproduction involves performing the observed behavior. Nabavi (2012) indicated that learners must remember that this is a stage in which practice makes perfect and therefore failing at the initial stage of preproduction should not be a deterrent to the learner. With further practice, the learner is guaranteed to sharpen their skills while less practice leads to amateur work and low productivity (Nabavi, 2012).

Motivation is the final step and is needed for the observed behavior to be successfully modeled (Nabavi, 2012). According to Bandura (1977), reinforcement and punishment impact motivation; when the behavior is modeled correctly, the learner is rewarded, and when the behavior is modeled poorly, the learner is punished. In addition, when a learner observes a peer being rewarded for proper modeling of behavior, they can be motivated to keep going so as to be rewarded as well, and when punishment occurs, the behavior can be extinguished (Nabavi, 2012).

Because I sought to understand the lived experiences of East African immigrants to the United States and the contribution of those experiences to their perceptions on mental illness, using social learning theory provided information on the various forms of learning that contributed to changes in mental illness perception and how the modeling process was used to ensure that learning would be successful. According to Nabavi (2012), social learning theory has been used effectively in several areas such as schools, workplaces, and communities to observe and model productive and positive behaviors.

As East African immigrants in the United States integrate into a society where mental illness is not as highly stigmatized and where individuals with mental illness are able to prosper, they can observe, imitate, and later model the behavior. Elo et al. (2015) indicated that many East African immigrants in the United States work in health care or mental health fields as direct supports, nurses, doctors, social workers, and case managers. Health care is a field that provides social learning through the opportunity to experience and observe others experiencing mental illness in a different way from what is the norm in East African countries.

Berry's Acculturation Model

Acculturation is the process of cultural contact and exchange through which groups or individuals adopt values and practices of a culture that was not originally their own (Cohen & Lilach, 2018). Acculturation can occur at a greater or lesser extent as the individual or group's original culture often remains internally intact but is changed by the process (Cohen & Lilach, 2018). Acculturation does not have a specific time frame in which it happens as it can occur among tourists and individuals who travel briefly to different communities (Cohen & Lilach, 2018). Berry (2007) suggested that an individual experiences at least two types of changes when exposed to two or more cultures. At one level, behavioral change affects the way the individual acts in areas such as speech, eating habits, dress styles, and self-identity (Berry, 2007). A second level, often referred to as acculturative stress, includes the emotional reactions of the individual to changes such as anxiety or depression (Berry, 2007). Acculturative stress occurs due to various

reasons such as the realization of how different the new culture is from the original culture and the need to learn new beliefs and behaviors (Berry, 2007).

According to Berry (2007), individuals have multiple responses to acculturation, which are referred to as acculturation strategies or modes. The strategy that an individual chooses depends on previous situations such as the individual's level of engagement with each culture and particular behavioral expectations and attributes (Berry, 2007). Additionally, the choice of strategy that the individual makes is indicative of their attitude toward their culture of origin and the new culture (Berry, 2007). Berry's model of acculturation emphasizes two dimensions that reflect the individual's positive or negative attitudes. One dimension is toward the maintenance of the original culture and identity, and the other is toward the preferred level of association with the new culture (Berry, 2007). Berry (1994, 2001) described four strategies through which individuals approach acculturation that result from the interaction of the two dimensions: assimilation, integration, marginalization, and separation.

Assimilation

According to Berry (2007), assimilation occurs when an individual prefers to decrease their culture of origin and chooses to largely identify and interact with the new culture. This is mostly common when the individual comes from an ethnic minority group and the new culture is a dominant one (Berry, 2007). Assimilation is often used when the individual places little or no importance on retaining their original culture but places great importance on fitting in and creating relationships with the new culture (Berry, 2007). The goal with assimilation is that the individual eventually becomes

culturally identical to the culture they have assimilated (Berry, 2007). Assimilation mostly occurs in societies in which the new members are absorbed by the new culture and with individuals who do not consider their culture of origin as important (Berry, 2007).

Separation

According to Berry (2007), when the individual prefers to hold on to their original culture and prevents interaction and learning about the new culture, they are using the separation strategy. Separation is often used when little importance is placed on adopting the new culture and great value is placed on preserving the original culture (Berry, 2007). Individuals use separation with the goal of retaining their original culture and rejecting the new culture, and this often occurs in racially segregated societies (Berry, 2007). Individuals who adopt the separation strategy of acculturation often value their cultural norms and beliefs and despise those of the new culture and will go to great lengths to avoid activities and relationships that may increase their adoption and acceptance of the new culture (Berry, 2007).

Marginalization

Individuals who use marginalization strategy are not overly involved in maintaining their culture of origin, or in learning the new culture (Berry, 2007). Marginalization is therefore, often practiced by individuals who neither identify with their original culture, nor with the new culture (Berry, 2007). Marginalization often ends with the individual being pushed aside, forgotten, or overlooked by the society (Berry,

2007). Marginalization often occurs in societies that practice cultural exclusion which makes it uninviting for the newcomer to integrate (Berry, 2007).

Integration

Integration strategy is used by individuals who are interested in maintaining their culture of origin and participating and learning the new culture (Berry, 2007). Great importance is placed on adapting to the new culture and maintaining the original culture, and often leads to creation of multicultural societies (Berry, 2007). Integration strategy is common in immigrant communities and in communities with high percentages of ethnic and racial minorities (Berry, 2007). Individuals who use integration are often considered bi-cultural and are known to switch between behaviors and values when they move between different cultural groups (Berry, 2007).

Because I sought to understand lived experiences of East African immigrants in the United States and their perceptions of mental illness stigma, Berry's (2007) acculturation model was used to understand how East African immigrants navigated the mental health culture in the United States. Berry's (2007) acculturation model was useful in explaining strategies used to learn and adapt the mental health practices and norms of the United States specifically changes in the perceptions of the participants. According to Berry (2007), individuals gravitate toward a specific strategy based on the level of importance they place on their original culture and on the new culture. Berry's (2007) acculturation model also provided insight on the mental health norms and beliefs in the United States and how East African immigrants rate them in terms of importance based on the acculturation strategies that they chose.

Literature Review

The following sections present a review of the literature in relation to key variables of the study. These include East Africa and mental health, prevalence of mental illness in East Africa, mental illness stigma and its causes in East Africa, cultural, social, and religious perspectives of mental illness in East Africa, East African immigrants in the United States, and cultural, social, and religious perspectives of mental illness in the United States.

East Africa and Mental Health

To provide an understanding of East African immigrants and their perceptions of mental illness, this section provides review of literature on the prevalence of mental illness in East Africa, mental illness stigma in East Africa, and the cultural, social, and religious perspectives of mental illness in East Africa. Because I focused on understanding experiences of East African immigrants in the United States, literature on the cultural, social, and religious perspectives of mental illness in the United States will also be presented. Understanding the cultural differences between East Africa and the United States indicated the need to explore the experiences of East African immigrants in the United States.

I focused on understanding perceptions of mental illness of East African immigrants, 20 years or older, in the United States. I compared perceptions of mental illness and mental illness stigma that the participants held while living in East Africa to their current perceptions of mental illness and mental illness stigma. I also aimed to understand how varying societal, cultural, religious, and personal experiences contributed

to changes in the perception of mental illness and to individuals with mental illness. Because mental illness stigma is learned or taught by societal, cultural, religious, and personal experiences, Bandura's (1997) social learning theory and Berry's (2007) acculturation model guided the study.

Because I sought to understand the variations in perceptions of mental illness among East African immigrants in the United States, understanding the prevalence of mental illness in East Africa was important. Mental illness stigma in East Africa was also addressed including the causes of the stigma against individuals with mental illness. Additionally, the cultural, religious, and social perspectives of mental illness in East Africa and in the United States were also addressed. Information on East African immigrants in the United States is also presented.

Prevalence of Mental Illness in East Africa

Because the current study was on the perceptions of mental illness and mental illness stigma among East African immigrants, understanding the prevalence of mental illness in East Africa provided some justification for the study. Mental illness is often referred to as a silent killer in East Africa because its existence is not acknowledged (Monteiro, 2015). However, as it is discussed in this section, mental illness is a major problem to East Africans and it needs to be understood (Jenkins et al., 2012). An epidemiological survey carried out by Jenkins et al. (2012), in a rural town in Kenya indicated that there was a 10.8% prevalence rate of common mental disorders (CMD). The researchers used random sampling to select 2% of the 50,000-adult population in Maseno town and used the Clinical Interview Schedule-Revised to determine the

prevalence of common mental disorders (Jenkins et al., 2012). The results of the research also indicated that higher rates of illness were reported in individuals who were older and in individuals with poor physical health (Jenkins et al., 2012). The results did not indicate gender differences in the prevalence of CMD (Jenkins et al., 2012).

According to WHO (2017), 1 in 4 persons in East Africa suffers from a mental illness. A study conducted in 2010 in East Africa indicated that mental and substance use disorders accounted for 19% of all disability, with the associated burden of life from major depressive disorder (MDD) being the biggest contributor as approximately 40% of individuals with a disability also suffered from MDD (Charleston et al., 2014). Schizophrenia followed MDD and was considered to be the most disabling condition among all diseases in the Global Burden Disease (GBD) study. Bipolar came in third place followed by alcohol and opioid dependence (Charleston et al., 2014). The study projected that by 2050, more than 27 million people in East Africa would be suffering from a mental illness, a significant jump from the 10 million during the time of the study in 2010 (Charleston et al., 2014).

A 2013 study carried out in Nyanza province in Kenya indicated that the prevalence of mental illnesses was 10.3% with depression, anxiety, and obsessive-compulsive disorders being the most common mental illnesses (Jenkins et al., 2015). The researchers conducted repeat household surveys of CMD and the associated risk factors with 1,158 households in Maseno town (Jenkins et al., 2015). The researchers tested the hypotheses that the prevalence of CMD would increase between 2004 and 2013, and that as in 2004, there would be no gender difference in the prevalence of CMD in 2013

(Jenkins et al., 2015). The results of the study indicated that in 2013, the prevalence of CMD was significantly higher if the individual was female, widowed, divorced, and above the age of 60 (Jenkins et al., 2015). According to WHO (2017), depression and anxiety were the highest ranked mental health illnesses among Kenyan women. The 2015-2030 Kenya Mental Health policy indicates that mental illness continues to rise in Kenya with 20-25% of individuals who seek treatment from a health care professional presenting with symptoms of one or more mental illnesses (WHO, 2017).

A review of research by Molodynski et al. (2017), indicated that close to 35% of Ugandans have a mental illness with up to 15% needing treatment. Molodynski et al. (2017), reviewed 14 studies in the study of mental health care in Uganda, with a focus on the challenges faced by individuals with mental illness. The study concluded that due to civil unrest in Uganda, the percentages that were reported in many of the research findings are believed to be higher as parts of the country have been affected by war and disease which are known contributors of mental illnesses including post-traumatic stress disorder, depression, and anxiety (Molodynski et al., 2017). Denur et al. (2019) conducted a study that indicated that in Ethiopia, the prevalence of common mental illnesses such as depression and anxiety is 39.2%. The researchers conducted a cross-sectional study from May to June 2018 at a hospital with a population sample that was randomly selected using systematic sampling of adults who attended the outpatient department of the hospital (Denur et al., 2019). The data was collected using a pre-tested interviewer administered questionnaire that contained CMD as the dependent variable and several other explanatory variables that included socio-demographic characteristics,

clinical factors, social support, and substance use (Denur et al., 2019). The results of the study indicated that the percentage of mental illnesses fluctuated between 23% to 58% based on the medical setting, gender, and region of the country (Denur et al., 2019). According to WHO (2016), one in three Somalis had a form of mental illness. Because of the ongoing war in Somalia, mental illness prevalence is presumed to increase at three times the rate of the neighboring East African countries like Uganda and Kenya (WHO, 2016). War ridden South Sudan has also seen an increase in mental illness with an estimated 36% of the population having post-traumatic stress disorder (Mogga, 2019).

Mental Illness Stigma and its Causes in East Africa

In East Africa, individuals with mental illness are not met with empathy from community and family members. Rather, social ostracism, discrimination and violation of basic human rights is often what individuals with mental illness face (Kopinak, 2015). In Somalia, the practice of chaining patients to beds both in hospitals and at home is viewed as normal because individuals with mental illness are believed to be possessed by evil spirits and keeping them chained is meant to prevent the spread of the evil spirits to others (WHO, 2016). Individuals with mental illness are considered a threat to society are also often imprisoned, chased, and insulted on the streets rather than being treated (WHO, 2016). Additionally, the individual's caretakers and next of kin are often the people who commit the brutal and discriminatory treatment because they believe it will cure the illness (WHO, 2016).

Although East Africa has several tribes all with different beliefs, the common belief in supernatural possession, evil spirits, or punishment by higher powers hinders the

acceptance of mental illness among the communities (Monteiro, 2015). Because of this belief, any illness that is not understood is associated with the supernatural rather than considering mental illness as a possibility and as a result, individuals who are sick often taken to traditional healers (Monteiro, 2015).

Additionally, mental illness is believed to run within the whole family and therefore all family members and their close relatives often experience stigma and isolation from the community (Monteiro, 2015). Additionally, other families will not allow their family members to marry into a family with a member that has mental illness (Monteiro, 2015). This belief system leads to unhealthy responses from individuals with mental illness such as suicide ideations and reluctance in seeking appropriate treatment (Marangu et al., 2014). In Uganda, individuals with mental illness experience discrimination, exploitation and exclusion from society, are often refused financial services, and denied employment (Bailey, 2014).

Cultural, Social, and Religious Perspectives of Mental Illness in East Africa

Attitudes toward mental illness vary among individuals, cultures, families, ethnicities, and countries, and are often shaped cultural, social, and religious teachings (Egbe et al., 2014). In East Africa, mental illness is culturally and spiritually associated with divine wrath and the will of God, witchcraft, possession of spirits, and other supernatural causes (Atilola, 2016). Because of the cultural and spiritual perspectives of mental illness, individuals mainly seek answers for their symptoms from traditional healers or witch doctors (Amuyunzu-Nyamongo, 2013). Mbwayo et al. (2013), indicated that in Uganda, more people reported using the services of a traditional healer when they

experienced symptoms that could not be explained by common medical illnesses such as malaria and tuberculosis. Ngoma et al. (2013), reported that individuals in Tanzania who had symptoms of a mental illness preferred to receive treatment from a traditional health center where traditional healers and remedies were used rather than going to a primary health clinic.

In addition to traditional healers, individuals with mental illness also turn to spiritual leaders or church members for treatment in the form of prayers (Sorketti et al., 2013). Spiritual treatment often involves fasting and praying for several days as well as making sacrifices and offerings in many forms including money, poultry, land, and livestock (Sorketti et al., 2013). Prayer and fasting is used by individuals and families who relate the mental illness to punishment from God for the sins of their parents and other ancestors (Sorketti et al., 2013). Ventevogel et al. (2013), indicated that individuals with mental illness in some communities of Burundi and Southern Sudan are often taken to churches and other religious houses such as temples and mosques and left there for several days, sometimes up to a few months for church and community members to pray for them. The individuals are not allowed to leave unless they are believed to be cured which has led to death by suicide of some of the individuals (Ventevogel et al., 2013).

From the social perspective, mental illness in East Africa is referred to as a silent epidemic as many families hide family members that have a mental illness to protect them from the stigma and discrimination associated with mental illness (Ndetei et al., 2015). Individuals with mental illness are viewed as a social burden and a nuisance and therefore are often kept away from social functions and community gatherings

(Makanjuola et al., 2018). In schools, individuals known to have a mental illness are often kept separate from other students because they are perceived to be contagious and will spread their inadequacies to the other students (Ndetei et al., 2015). Ndetei et al. (2015), conducted a study in two separate districts of the eastern province of Kenya. The researchers conducted and analyzed cross-sectional survey data from 4,585 primary school children (Ndetei et al., 2015). The researchers examined relationships between stigmatizing attitudes and age, gender, district, religion, class grade, and the parent's employment status (Ndetei et al., 2015). The results of the study indicated that stigma decreased when age increased, boys had higher stigma scores compared to girls, students from the rural districts had higher average stigma scores as compared to those from the peri-urban districts, and that students who were not in the appropriate class grades for their age had lower stigma scores than those who were in the appropriate class grades for their age (Ndetei et al., 2015).

Because it is considered a family disease, one of the major effects of the social perspectives on mental illness in East Africa is its effects on women (Amuyunzu-Nyamongo, 2013). This is because mental illness greatly reduces the chance of marriage for women who have a history of mental illness or who come from a family with a history of mental illness (Amuyunzu-Nyamongo, 2013). This stigma makes many households with mentally ill family members hide them for fear of being prejudiced and excluded from their communities (Amuyunzu-Nyamongo, 2013). According to Amuyunzu-Nyamongo (2013), negative social stigma is further heightened by inefficient

focus at the policy level and inadequate financial and technical investments at the national level to address mental health.

East African Immigrants in the United States

Because the research study was with East African immigrants, it is important to provide a background on the migration of East Africans to the United States. This is because it may provide a better understanding of the perspectives of East African immigrants living in the United States. Additionally, the study might contribute to the level of services that the United States can offer to non-assimilated East Africans.

East Africa is made up of a number of developing countries including Burundi, Eritrea, Ethiopia, Kenya, Rwanda, Somalia, Sudan, Tanzania, and Uganda. East Africa continues to have a myriad of political, religious, social, and economic conflicts including war, famine, and floods that have a large impact on the psychosocial well-being of the people (Amuyunzu-Nyamongo, 2013). The ongoing conflicts have created an environment of political, social, economic, and religious instability for East Africans making the need to migrate to other parts of the world such as the United States seeking stability (Amuyunzu-Nyamongo, 2013).

Although the transatlantic slave trade brought hundreds of thousands of Africans to the United States, voluntary immigration is a newer trend that was made easier by the Refugee Act of 1980, for immigrants to flee war torn countries such as Ethiopia (Woldeab et al., 2019). According to the Migration Policy Institute (2019), a little over two million sub-Saharan Africans lived in the United States in 2018 and that there had been a 52% increase from the reported number in 2010. The reasons for migration vary

from individuals fleeing wars in Ethiopia, Somalia, and Sudan, to skilled individuals looking for better opportunities, to individuals reuniting with family members who are already living in the United states (Migration Policy Institute, 2019).

The Migration Policy Institute (2019), of the more than two million sub-Saharan African immigrants, 730,000 came from East Africa with Ethiopia, Kenya, and, Somalia having the greatest percentages. Although East African immigrants in the United States settle in different cities and states across the country, larger percentages are found in cities in Minnesota, Texas, New York, California, Maryland, New Jersey, Massachusetts, South Dakota, and Virginia (Woldeab et al., 2019). Many East African immigrants begin by settling in communities occupied by people from similar countries and then subsequently begin to venture out to different communities and cities where they get more exposure to the cultures and norms of the United States(Migration Policy Institute, 2019).

As East African immigrants spread out to various communities in the United States and begin new lives in new communities, acculturation occurs as they learn the culture in their new communities (Elo et al., 2015). According to Berry (2007), individuals in new societies develop strategies with which they navigate the new culture. These strategies are based on the importance that the individual places on the new culture as well as their original culture (Berry, 2007). With many East African immigrants in the United States working in the health care and mental health field, assimilation may be one of the strategies used to learn the culture in the United States (Elo et al., 2015). When

individuals make an effort to engage in the practices of the new culture, they are assimilating to those practices (Berry, 2007).

There is hope for the future of improved mental health systems in East Africa as the number of East Africans migrating to United States increases. With exposure and education many East Africans are beginning to see mental illness in a different way than what they were taught back home. East African immigrants see that individuals with mental illnesses can have long fulfilling lives and be influential members of society, rather than the burdens that they are perceived to be in East Africa (Kopinak, 2015). This does not however, mean that all East Africans will change their view on mental illness and be open to the various forms of modern treatment (Kopinak, 2015). However, there is hope and progress based on the several organizations in the United States that provide mental health services to East African communities. This is mainly because East Africans immigrants in the United States have dual citizenship and travel back and forth between East Africa and the United States there by having the chance to share their new learned experiences with individuals still in East Africa (Ship et al., 2014).

Cultural, Social, and Religious Perspectives of Mental Illness in the United States

The United States is made up of various ethnic groups such as European Americans, Asians, American Indian, Alaskan, and Pacific Islander natives, the Black population, and the Hispanic and Latino population (Abdullah et al., 2011). Because there are various ethnic groups, there are just as many attitudes, beliefs, and perceptions of mental illness (Abdullah et al., 2011). For example, some American Indian tribes stigmatize against all mental illnesses, some only stigmatize against specific mental

illness, and some do not stigmatize against any mental illness (Abdullah et al., 2011). Additionally, in the Asian population, mental illnesses are frequently seen as shameful because they do not align with the cultural norms of emotional self-control and conformity to family values (Bailey et al., 2011).

Carpenter-Song et al. (2010) indicated that European Americans regularly seek treatment for mental illness from mental health professionals and emphasized biomedical perspectives of mental illness unlike African Americans and Latino populations who emphasized non-biomedical interpretations. European Americans are reported to view psychiatric medications as a necessity in treatment and will often be open to the suggestion of medication as a form of treatment (Carpenter-Song et al., 2010). However, African Americans often refuse medication and find the suggestion to use medication frustrating and insulting (Carpenter-Song et al., 2010). African Americans and Latino populations report preference to natural ways of managing symptoms of mental illness such as exercise rather than taking medication (Carpenter-Song et al., 2010).

Despite the many cultural differences, societies and communities are often blended with individuals across all ethnic backgrounds which has translated to varying perspectives of mental illness (Bailey et al., 2011). As a society, the United States continues to fight against mental illness stigma by providing ongoing education to the population and also encouraging and prompting inclusivity of individuals with mental illnesses (Bailey et al., 2011). Government and non-Government funded agencies like National Alliance on Mental Illness (NAMI), Substance Abuse and Mental Health Services Administration, the National Suicide Prevention Lifeline, American

Psychological Association, and Health and Human Services Agency all strive to remind individuals with mental illness that they are as valuable as everyone else and that they are not alone (NAMI, 2019). One of the biggest causes of mental illness stigma is lack of education and therefore with many agencies educating the public on mental illness, the rates of mental illness stigma due to ignorance is decreasing (Parcesepe & Cabassa, 2013).

Additionally, according to the 1990 Americans with Disabilities Act, it is illegal to discriminate against individuals with disabilities in all areas of public life such as schools, jobs, transportation, housing, and all public and private areas open to the general public (NAMI, 2019). Individuals with mental illness are covered by this Act and have therefore seen a significant decrease in employment, housing, and education discrimination due to a mental illness (Parcesepe & Cabassa, 2013). Constant coverage of the media depicting individuals with mental illness as normal and public figures and icons like Oprah Winfrey being open about their struggles with mental illnesses helped create a more tolerating environment for individuals with mental illness (Parcesepe & Cabassa, 2013). This does not mean mental illness stigma does not exist, it just means that society as a whole is trying harder than before to be mindful and accepting of individual struggles and differences and continued education and exposure will only make for a better community (Parcesepe & Cabassa, 2013).

According to Almanzar (2017), mental illness stigma continues to exist among devout Christians as mental illness is not often addressed in churches and other Christian and religious settings. There continues to be a significant lack of knowledge and

misinformation about the causes and treatment approaches to mental illness which leads to under recognition and under treatment of Christians with mental illness (Almanzar, 2017). However, with faith based organizations such as Jewish Family Services, Catholic Charities, Young Men's Christian Association, and the Salvation Army, Christians are beginning to understand that seeking psychological treatment does not mean losing faith (Almanzar, 2017). Faith based organizations now work with mental health providers to emphasize the importance of incorporating religious practices in the treatment of mental illness (Almanzar, 2017). Collaboration between mental health professionals and religious entities provide the opportunity for Christians to develop different perspectives of mental illness and to recognize the benefits of getting treatment from a mental health professional (Almanzar, 2017).

Summary and Conclusions

This chapter of the study discussed the review of literature to include the prevalence of mental illness in East Africa, mental illness stigma in East Africa, and the social, cultural, and religious perspectives of mental illness in East Africa. A number of studies described mental illness stigma in East Africa including the long-term effects of mental illness stigma to individuals and communities (Bailey, 2014, Kopinak, 2015, Marangu et al., 2014, Monteiro, 2015, WHO, 2016). Social, cultural, and religious perspectives of mental illness in the United States was also discussed. However, research was limited on the perception of East African immigrants in the United States regarding mental illness. This gap is what I sought to fill. The hope is that filling this gap will help

in informing services in the United States regarding cultural concerns for East African immigrants.

Existing research indicated that mental illness stigma is learned through cultural, religious, or societal norms and therefore welcoming behavior can be learned through social learning theory or acculturation. Available literature indicated that there is a significant percentage of mental illness in East Africa and continuous stigma has made mental illness the silent epidemic because individuals with mental illness suffer alone for fear of being ridiculed (Egbe et al., 2014). Individuals with mental illness therefore often opt to seek help from traditional healers because they find more comfort in having an unexplainable illness than to be diagnosed with a mental illness (Atilola, 2016).

Research by Parcesepe and Cabassa (2013) indicated that as a blended society, mental illness stigma is highly opposed in the United States as many cultures and religions work together to provide safety and normalcy for individuals with mental illness. Many programs all over the country have been set up to ensure that mental health services are easily accessible to anyone who needs it and individuals with mental illness are also portrayed in a positive way to reassure society that a mental illness does not have to be crippling (NAMI, 2019). This has presented a more welcoming and tolerant culture toward individuals with mental illness in the United States than in East Africa. The hope is that the results of the research study may contribute to the establishment and improvement of mental health services in East Africa as well as increased awareness about the negative effects of mental illness stigma. This will be achieved by sharing the results of the study with organizations that already provide mental health services to East

Africans in the United States and in East African with organizations such as Alliance for African Assistance, WHO, and International Rescue Committee. Additionally, the research may contribute to cultural competence of mental health providers in the United States when treating East African immigrants.

Chapter 3: Research Method

In this qualitative study, I sought to understand the lived experiences of East African immigrants in the United States and the impact of these experiences on the East African immigrants' perceptions of mental illness. I sought to understand any changes in the perception of mental illness of the participants, as well as the experiences that led to the changes. I sought to fill the gap in the professional literature by understanding the experiences of East African immigrants in the United States and their present perceptions of mental illness. Individual interviews and focus group discussions were used to obtain data to answer the research questions. This chapter includes a description of the research design and rationale, as well as the methodology of the study. In addition, this chapter covers the role of the researcher, sample size, sampling strategy, research questions, instrumentation, data collection process, data analysis process, and ethical procedures. The study's validity and trustworthiness are also covered in this chapter.

Research Design and Rationale

According to Ravitch and Carl (2016), a rationale is the reason why a study matters and why the approach being used is appropriate for the study. A rationale is the researcher's reasons or defense for carrying out the study. The following sections present the research questions that I attempted to answer, the research design and rationale, the role of the researcher, the participant selection process, instrumentation, sampling and sample size, procedures for recruitment, and the data analysis plan. The section also addresses issues of trustworthiness as well as ethical procedures that were followed.

Research Questions

The purpose of this study was to understand the lived experiences of East African immigrants in the United States and the impact of these experiences on the East African immigrants' perceptions of mental illness. The following research questions guided the study:

RQ1: What are the lived experiences of East African immigrants in the United States in relation to mental illness?

RQ2: How do East African immigrants to the United States describe their perceptions of mental illness in East Africa in comparison to the United States?

The research questions were formed to study the lived experiences of East African immigrants in the United States and their perceptions of mental illness. I used a qualitative and phenomenological approach. According to Ravitch and Carl (2016), qualitative researchers seek to understand a social problem by recognizing the significance of the problem to the individuals. In the current study, I attempted to understand the social problem of mental illness stigma among East African immigrants in the United States.

Design

Because I aimed to explore the experiences of East African immigrants in the United States, a qualitative approach was appropriate. Qualitative research involves an interpretive, naturalistic approach to the world, meaning qualitative researchers study things in their natural setting and attempt to interpret phenomena the way people view them (Burkholder et al., 2016). Additionally, qualitative researchers seek to discover in

narrative form what people do in their everyday lives and what their actions mean to them (Ravitch & Carl, 2016). Qualitative researchers answer research questions by collecting data through naturalistic techniques such as case studies, interviews, focus group discussions, and observations, unlike quantitative researchers who answer research questions using numeric data and hypotheses (Burkholder et al., 2016).

Rationale

Qualitative methodology was appropriate for this study because few participants would be required and data collection could occur in a natural setting (see Burkholder et al., 2016). Having few participants for the study allowed for the exploration of exclusive experiences through in-depth individual interviews, as well as focus group discussions with the same participants. I performed face-to-face individual interviews with each participant to collect detailed information about the participant's past and present experiences that might be too personal or private for the participant to share with anyone other than me. In addition, the focus group discussions provided an opportunity for the participants to share experiences that they may have thought to be irrelevant during the individual interviews. Individual interviews and focus group discussions provided the participants the opportunity to explain their experiences in detail, as well as share their past and present perceptions of mental illness. As data collection techniques, interviews and focus group discussions are able to capture the essence of lived experiences of individuals, which is what I aimed to do (see Burkholder et al., 2016).

By conducting the interviews and focus group discussions in the United States, I collected data in the natural setting of East African immigrants living in the United

States. This qualitative study was important in understanding the lived experiences of East African immigrants in the United States. Individual interviews and focus group discussions provided the opportunity for in-depth narratives with participants regarding their experiences and perceptions of mental illness. After the interviews and discussions, the data's themes were identified to explain the participants' experiences and perceptions.

I chose to use a qualitative approach to provide participants with the opportunity to share their experiences and perceptions in detail. Interviews and focus group discussions provided the opportunity for in-depth investigation and understanding of the participants and population. Additionally, interviews and focus group discussions allowed the participants to articulate their experiences in their own words while allowing me to follow up with any questions when clarification was needed (see Ravitch & Carl, 2016). This study was phenomenological in nature because I explored the participants' unique experiences in relation to mental illness stigma. According to Ravitch and Carl (2016), phenomenology is a helpful approach when researching the experiences of individuals who have encountered the same phenomenon.

Role of the Researcher

I was the primary researcher of this study. I conducted individual interviews to obtain detailed background information from the participants about their past and present experiences and perceptions of mental illness. The individual interviews were semistructured to allow for more discussion with the participants rather than straightforward questions and answers. This provided an opportunity to probe for more details whenever necessary. See Appendix B for the interview questions.

I also moderated the focus group discussions. As a moderator, I ensured that all participants had enough time to discuss their experiences and that no one person dominated the discussion. I also ensured that the discussions stayed on topic and that participants treated each other respectfully by ensuring that every participant shared only what they were comfortable sharing.

Methodology

I used a phenomenological design to understand the lived experiences of East African immigrants in the United States in relation to their perceptions of mental illness. According to Ravitch and Carl (2016), phenomenological researchers study the lived experiences of an individual. Phenomenological studies typically include interviews that enable the participants to share as much or little detail as they please, and allow the researcher to ask detailed questions and to follow up as need (Ravitch & Carl, 2016). Additionally, in a phenomenological study, the researcher is able to collect data from a small group of participants often using interviews that allow for the researcher and participants to form a close connection (Ravitch & Carl, 2016).

Participant Selection Logic

The population of interest for this study was East African immigrants living in Southern California in the United States, a location convenient to me. The participants were individuals who had migrated to the United States as adults and had lived in the country for more than 2 consecutive years since migrating. For representation of several countries and cultures, the participants were from different East African countries. In the event that there were two or more participants from the same country, I ensured that the

participants from similar countries came from different regions or tribes of the country. Additionally, all participants were fluent in English. Gender and religion were not factors in participant selection.

Sampling and Sampling Procedures

I recruited participants using purposeful sampling. In qualitative research, purposeful sampling is encouraged and used because the researcher chooses participants who will provide the data that are being sought (Patton, 2015). Selecting the right sample helps to enrich the information that is gathered during data collection (Ravitch & Carl, 2016). Additionally, purposefully selecting a sample ensures that the information obtained from the participants will answer the questions being investigated (Patton, 2015). Because the current study was phenomenological in nature, purposeful sampling ensured that the participants selected for the study had similar experiences with the phenomenon that was being studied. By choosing participants who had similar experiences, I was able to answer the research questions that guided the study.

According to Ravitch and Carl (2016), although there is no set sample size for a qualitative study, the sample size should be able to provide data saturation. Saturation is the point when the collection of new data does not shed further light on the topic that is being investigated (Ravitch & Carl, 2016). Saturation occurs when the researcher sees similar instances over and over again (Ravitch & Carl, 2016). To collect data for the current study, I recruited 12 participants from at least three of the East African countries and had two focus group discussions, each with six participants. Focus group discussions are a research method used for collecting qualitative data to gain a deeper understanding

of a specific issue or topic (Laureate Education, 2016a). Focus groups are useful because the researcher can gather the perceptions of a group of individuals in one setting, and saturation is usually reached in two to three sessions (Laureate Education, 2016a).

To recruit participants, I prepared a flyer requesting interested individuals to sign up for the study (see Appendix A). The flyer included details about the study, such as the reason for the study and the topic that would be discussed. Information about me, such as my name, degree of study, and contact information was also included in the flyer. When the flyer was ready, I contacted East African restaurant owners, school administrators, organization management, and social media group administrators for permission to post the flyer on their resource or notification boards. Some of the resource boards that were considered included San Diego Community College, Alliance for African Assistance, United Women of East Africa Support Team, International Rescue Committee, and Facebook groups such as Ugandan North American Association and Kenyans/Americans in the United States of America. These groups were made up of thousands of members who had lived in both the United States and East Africa and were therefore likely to provide a good sample pool. Snowball sampling was also used by asking participants who had already been recruited and interviewed to refer any of their friends who met the study's criteria. This technique allowed me to recruit participants who met the selection criteria until the required sample size was reached.

After the flyers were posted, I began to vet individuals who responded with interest in participating in the study. Once all the participants had been selected, data collection began. I provided the participants with a questionnaire via email to collect

demographic information. Once the questionnaires were returned, I arranged individual interviews with each of the participants. After the individual interviews, I scheduled two focus group discussions with the same participants. Each focus group consisted of six participants. After the discussions, all audio recordings were transcribed and analyzed for themes.

Instrumentation

I used a demographic form to collect the participant's demographic information (see Appendix C). The information that was collected included gender, age, country of origin, when the individual moved to the United States, religion, and profession. I used face-to-face individual interviews to gather information about the participant's lived experiences in their country of origin and in the United States, as well as their perceptions of mental illness. The individual interview questions were designed to elicit information on the individual's definition of mental illness, what they believed causes mental illness, how they believe mental illness should be treated, and their perception of individuals with mental illness. The focus group discussions were designed to elicit information on perceptions of mental illness in the participants' countries of origin, including what is assumed to cause mental illness, stigma associated with mental illness, and treatment practices for mental illness.

Procedures for Recruitment, Participation, and Data Collection

I recruited East African immigrants living in the United States who were born and raised in different East African countries. The plan was to speak to program managers and directors at some of the agencies in San Diego who worked with East African

immigrants, and to ask permission to post flyers on their resource boards. There were also several East African restaurants that attracted East Africans, and the plan was to ask for permission to post flyers on their resource boards or counters. I also posted flyers at the community colleges such as San Diego City College, Kearney Mesa College, and Educational Cultural Complex as well as on various East African Facebook groups to reach as many potential participants as possible.

I provided the participants who had been recruited for the study with an informed consent form. The informed consent form indicated that participation was voluntary and the participants could withdraw at any time. The form also indicated the purpose of the study, significance, procedures, and the plan for distributing the results of the study. I also explained how privacy and confidentiality would be maintained before, during, and after the study. The participants were told about the time commitment for the individual interviews as well as the focus group discussions. Additionally, the participants were compensated with either breakfast or lunch depending on what time the interviews and focus group discussions took place.

Data Analysis Plan

I began the data analysis process by reviewing the recorded audio from the interviews and focus group discussions and transcribing them into a Word document. After transcribing the audio recordings, I reviewed the transcripts for codes that were then tracked for themes. According to Ravitch and Carl (2016), a code is a common concept in the data and themes are used to organize the collected data. A code is a word

or phrase that the researcher assigns to phrases or sentences in the data (Burkholder et al., 2016).

I then tabulated and analyzed the completed transcripts using the NVivo thematic analysis software. Thematic analysis was appropriate for the study because it made it possible to identify codes and themes from the interviews. According to Ravitch and Carl (2016), thematic analysis includes similarities and differences within the data and gives explanations of the phenomenon while answering the research questions. Themes that answered the research questions were identified using a coding method to separate different information components from the interviews to describe the features connected to the research topic in which I sought to answer lived experiences of East African immigrants and their perceptions of mental illness. Therefore, themes answering the research questions were what I was looking for. After coding, the themes were categorized and stored in a memory card for record keeping. The memory card and all research materials will be kept in a locked safe that will be kept in the researcher's premises.

Discrepant Data

According to Ravitch and Carl (2016), discrepant data is data that does not fit into the common themes and patterns that have been identified after coding. The discrepant data was rigorously examined to assess whether it was more plausible to retain the common themes or to modify the conclusion of the study to include the discrepant data. When I could not confidently eliminate the discrepant data, the data was reported to allow the readers to make their own conclusions.

Issues of Trustworthiness

Burkholder et al. (2016), indicated that trustworthiness demonstrates a study's legitimacy. Furthermore, trustworthiness indicates that a study is dependable, credible, transferable, and confirmable (Burkholder et al, 2016). Trustworthiness also demonstrates that a researcher took the required steps to make sure that the data collection methods used were efficient and provided rich information (Burkholder et al, 2016). In qualitative research, validity is the researcher's ability to convey the participants' experiences accurately (Ravitch & Carl, 2016).

Credibility

Credibility represents the internal validity of a research study and is measured by how well the research represents the actual phenomenon (Morse, 2015). Credibility implies that the provided data confirms that the findings of the study are believable (Morse, 2015). Credibility can be attained through prolonged engagement, constant observation, peer debriefing, negative case analysis, reflexivity, member checking, progress partiality, and triangulation (Burkholder, et al, 2016). To achieve credibility in this research study, I used triangulation, member checking, and peer debriefing.

Member Checking

Member checking is a strategy that ensures participant validation, and that the researcher appreciates the participants' experiences (Ravitch & Carl, 2016). During this process, the researcher evaluates the various aspects of the research process such as, data collection and data interpretation (Ravitch & Carl, 2016). Additionally, the participants review the structural and textural narratives of the data and communicate whether their

experiences were captured by the data interpretation (Ravitch & Carl, 2016). I achieved member checking by providing the participants with the transcripts from the interviews for them to review and provide feedback about the authenticity of their experiences.

Triangulation

Triangulation is the process in which the researcher verifies the information in the study using a variety of methods (Morse, 2015). Triangulation reduces the risk of systematic biases and chance associations that occur as a result of using specific methods, and therefore allows for better assessment of the data (Morse, 2015). According to Ravitch and Carl, 2016, using triangulation and audit trails will ensure dependability. I achieved triangulation by having the dissertation committee review the research study during each step as well as the final findings.

Peer Debriefing

Peer debriefing is the process of using an impartial individual or colleague to examine the researcher's transcripts, general methodology, and final report (Ravitch & Carl, 2016). This individual must be someone who can be critical and that can challenge the researcher impartially (Ravitch & Carl, 2016). The objective in peer debriefing is for the impartial individual to challenge the researcher's data interpretation and research process (Ravitch & Carl, 2016). Peer debriefing provides the researcher with an opportunity to explain the research process and how they managed any biases that they had and how they came to the conclusions they did (Ravitch & Carl, 2016). I achieved peer debriefing by having my dissertation committee and a colleague review the research process and findings for impartial feedback.

Transferability

Transferability is the degree to which the study and its findings can be employed in real life (Burkholder, et al, 2016). The participants' social learning experiences and acculturation strategies can be shared with societies in which mental illness stigma is still highly prevalent with the aim of lowering mental illness stigma. To achieve transferability, I used variation in the selection of participants to determine how similar lived experiences are among East African immigrants in the United States.

Dependability

Dependability indicates the consistency in data collection, data analysis and reporting of findings of a study (Burkholder, et al, 2016). Dependability may be achieved through audit inquiry and triangulation, among other methods (Burkholder, et al, 2016). Audits offer details of how data was collected and how categories were created using field notes and memos as well as reflection journals showing all decisions made throughout the research process (Burkholder, et al, 2016). I achieved dependability by maintaining reflective journals throughout the research process and reviewed them when I was writing the final report.

Confirmability

Confirmability implies that other informed researchers will come to the same conclusions when they analyze the same data (Burkholder, et al, 2016). Confirmability can also be achieved by using audits (Burkholder, et al, 2016). For this study, I achieved confirmability by using audits that were conducted throughout the research process by my dissertation committee who reviewed my findings.

Ethical Procedures

I began by obtaining approval from Walden University's Institutional Review Board (IRB) through completing the IRB application process. I included cooperation agreements from the agencies, restaurants, and Facebook groups that were used for participant recruitment with the application. I also provided the IRB with the informed consent form that was given to the participants before they agreed to sign up for the study and emphasized that participation was voluntary. The consent form included the purpose and benefits of the study and a plan on how to distribute the results from the study. The consent form also included a guarantee for privacy and confidentiality and how I planned to achieve that. Time commitment required from the participants and their compensation was also described in the informed consent. Although the participants of this study were not a vulnerable population, any possible risks such as feeling unhappy or shameful due to sensitive topics that might come up was also indicated in the informed consent. To ensure that all the participants remained in a good mental health state after the study, participants were provided with information on how to reach out to mental health clinicians at Alliance for African Assistance who were culturally competent to provide services to individuals from East Africa.

All the information that was collected and used during this study was kept in a small safe in my premises. The signed consent forms, raw data, recordings, transcripts, journal, and a password protected memory card were also locked in the safe when they were not in use. The laptop that I used for the study was password protected and locked in my safe when it was not in use. I was the only one who had the password which

ensured that no one else could access and use the laptop without permission. The raw data was locked in my safe where it will remain for 5 years, after which it will all be professionally destroyed.

Summary

I used a qualitative design to form a more comprehensive understanding of the lived experiences of East African immigrants in the United States and their perceptions of mental illness. The semi-structured interviews provided the structure for an impartial and holistic approach in determining the outcomes of the study. Coding was used to determine themes collected from the data and all data outcomes were verified for consistency and accuracy. Additionally, everything was recorded and labeled appropriately to avoid any misappropriation.

The goal was that this study would be beneficial in improving access to mental health services in the East African community, both in the United States and in East Africa. The study could also be beneficial in reducing the stigma associated with mental illness in the East African community. Sharing of the results with existing mental health organizations in East Africa may contribute to positive change in the mental health systems in East Africa. Understanding some of the barriers to the access of mental health services will contribute to improvement in repairing the existing services and establishing of new ones. Finally, the study could also contribute to understanding how to provide culturally sensitive mental health services to individuals in a diverse community.

In conclusion, this chapter portrayed the research method, the role of the researcher, methodology, participant selection, data collection, and data analysis plan.

The sample and sampling strategy offered an explanation on how the sample size was determined and the procedures for recruitment described how the participants for the study were chosen. The ethical procedures were also covered in this chapter. Chapter 4 will provide the findings and detailed discussion of the results from the data analysis.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to understand the lived experiences of East African immigrants in the United States and the impact of these experiences on the East African immigrants' perceptions of mental illness. In this chapter, I present an analysis of the findings from 12 semistructured individual interviews with East African immigrants living in the United States. In the interviews that were conducted virtually, I asked open-ended questions to gather in-depth data on topics such as the participant's definition of mental illness; cultural, social, and religious experiences with mental illness; knowledge about mental illness; perception of mental illness; changes to perceptions of mental illness; and treatment of mental illness. I used open-ended questions to allow for deeper and clearer answers to the two research questions that provided the foundation of this qualitative study: .

RQ1: What are the lived experiences of East African immigrants in the United States in relation to mental illness?

RQ2: How do East African immigrants to the United States describe their perceptions of mental illness in East Africa in comparison to the United States?

This chapter includes a summary of the themes that emerged from analyzing the data that were collected during the interviews. The chapter also provides a description of the data collection and analysis procedures, the thematic analysis, study results, and how the collected data answered the research questions. This chapter is organized into subsections on setting, demographics, data collection, data analysis, evidence of trustworthiness, results, and a summary.

Setting

The interviews were conducted between January 2021 and February 2021. Approximately 300 flyers were distributed in East African restaurants in the San Diego area, in grocery stores in communities mostly occupied by East African immigrants, and in resource boards of organizations that work with the East African community. Additionally, flyers were posted on Facebook groups that are made up of East African immigrants in the United States. Because of the COVID-19 pandemic, I conducted semistructured individual interviews via Zoom with each of the 12 participants. The study's participants resided in different cities across the United States including San Diego, Los Angeles, Sacramento, Atlanta, Houston, Washington DC, Boston, and Baltimore. The interviews included video, so I was able to gather nonverbal information from the participants, such as facial expressions, in addition to verbal information. The video interviews also provided for a more personable experience than phone interviews likely would have provided. I was the only one in the room during each video call, and all participants indicated that they were in a place where they had the privacy that they needed.

Demographics

Participation in the study was limited to East African immigrants above the age of 20 who had migrated to the United States as adults and had lived in the United Stated for at least 2 consecutive years since migrating. The study included 12 participants who were recruited through purposeful sampling to ensure that the participants met the criteria that I was looking for, as well as to ensure diversity of the sample pool. I established the

demographic inclusion criteria during the recruitment process. The criteria were also indicated in the recruitment flyer and the demographic survey that was provided to the participants prior to the individual interview. Table 1 shows the demographics of the participants, including gender, age, year of immigration to the United States, age at immigration to the United States, country of origin, religion, and profession. The sample of participants included nine women and three men. All participants indicated that they understood what mental illness was; therefore, I did not need to provide an explanation.

Table 1

Demographic Information

Pseudonym	Gender	Age range	Country of origin	Year range of immigration	Age at immigration	Religion	Profession
PRSHA1	F	41–50	Somalia	2011–2018	41	Muslim	Other
PREMK2	F	41–50	Ethiopia	1991–2000	19	Christian	Medical
PRUAL3	F	31–40	Uganda	2001–2010	20	Christian	Accountant
PREWT4	F	20–30	Eritrea	2001–2010	18	Christian	Technology
PRKAK5	F	31–40	Kenya	2001–2010	20	Christian	Technology
PRRKD6	M	31–40	Rwanda	2001–2010	19	Christian	Technology
PRRUN7	F	31–40	Rwanda	2011–2018	22	Christian	Education
PRTSK8	M	31–40	Tanzania	2001–2010	26	Muslim	Technology
PRTAW9	F	41–50	Tanzania	1991–2000	25	Muslim	Medical
PRKVB10	M	20–30	Kenya	2011–2018	23	Christian	Education
PRKSM11	F	41–50	Kenya	1991–2000	20	Christian	Hospitality
PRUOJ12	F	51–60	Uganda	1991–2000	30	Christian	Hospitality

Data Collection

Data collection for the study included interviews with 12 participants. The sample was made up of nine women and three men. I conducted individual Zoom interviews with each participant. The interviews lasted between 30 minutes and 1 hour and were conducted at various times of the day based on the participant's availability. The interviews were video and audio recorded with the participant's consent using the Zoom

recording feature, and the audio recordings were then transcribed using the Zoom transcription feature. I used the interview questions in Appendix C to guide the virtual interview sessions.

During the interviews, I used follow-up questions to delve deeper into some of the answers for clarity and understanding. I observed the participant's body language and facial expressions after every question and offered the participant as much time as they needed to answer each question. I checked with the participants to make sure all questions were understood and provided clarity as needed. After each interview, I listened to the recorded audio and reviewed the transcripts to ensure that there was a match between the two. Because the transcription was automated through Zoom's transcription service, there was some discrepancy between the audio recordings and the transcription, mostly attributed to the participants' and my accents. I reviewed all of the audio recordings and transcriptions and made the necessary corrections. Once the transcriptions were complete, they were submitted to the participants for review. Once the participants had reviewed the transcripts, I used NVivo 12 for coding and thematic analysis.

Data collection did not include the focus group discussion as was originally planned. Additionally, the face-to-face individual interviews that were planned did not occur. I needed to adjust to the travel restrictions and stay-at-home order due to the COVID-19 pandemic. Only essential workers were allowed to leave their homes for work. Nonessential workers were expected to leave home only for purposes such as going to the grocery store or to the doctor. Additionally, I was unable to conduct virtual focus

group discussions because it was not possible to find a day, date, and time that would work for at least four participants, the minimum number of participants required for a focus group discussion (Ravitch & Carl, 2016).

Data Analysis

The data analysis included organization of the themes that emerged in NVivo. I used the NVivo 12 qualitative software from QRS International to analyze the data and develop themes. A theme generally involves a common concept in the data, and thematic analysis includes examination of relationships, similarities, and differences within the data (Ravitch & Carl, 2016). After reviewing the transcripts and audio recordings, I uploaded the transcripts into NVivo 12 and coded the interview questions into categories. I reviewed each interview question and each participant's response to the question, one at a time. I identified several emerging themes from the coding process based on the frequency of words.

I developed approximately 50 codes that included phrases or words that shared similar meanings and experiences. Examples of codes included fear of being called crazy, fear of embarrassing the family, kept in isolation, shunned from the community, hospital for crazy people, family will not know what to do, family will meddle, word spreads quickly, increased awareness, and mental illness stigma. The codes were then placed into categories based on commonalities. The categories were then used to develop the themes.

Evidence of Trustworthiness

Trustworthiness is important in all research studies. In quantitative studies, trustworthiness is achieved through the reliability and validity of the study's research

instruments (Creswell, 2012). In qualitative research, trustworthiness depends on the researcher's commitment to follow four core components: credibility, transferability, confirmability, and dependability of the research study's findings (Creswell, 2012).

Credibility

I used member checking and peer debriefing to confirm credibility. According to Ravitch and Carl (2016), participants review parts of the research that pertain to them during member checking. I provided the participants with the transcripts from the audio recordings for review. Each participant reviewed the transcript and confirmed that I had captured and understood their experiences. The participants were also asked to review the thematic analyses to further ensure that their feelings and experiences were captured. All participants validated that I had correctly portrayed their experiences and perceptions.

In peer debriefing, the research process, data analysis, and research findings are reviewed by the researcher's peer (Ravitch & Carl, 2016). I used Dr. Kitonga Ndindi as a peer. Dr. Kitonga has over 15 years of research and education and currently teaches at Chapman University. Dr. Kitonga is also the cofounder of Angeles workshop school in Los Angeles. Dr. Kitonga did not know any of the participants and was not involved in the interview process and data analysis. Dr. Kitonga reviewed the analyzed data and provided feedback as needed.

Transferability

According to Burkholder et al. (2016), transferability is the ability of the study's findings to be applied to other times and places. To achieve transferability, I used participant variation in the selection of the study sample to explore for similar lived

experiences among East African immigrants in the United States. This was done by having participants from various East African countries who lived in various cities across the United States. By using participants from different East African countries and in different U.S. cities, I was able to gain varying experiences and compare the data among the participants.

Dependability

To achieve dependability, I maintained an audit trail by documenting every part of the research process and recording the interviews for safe keeping. I also used perspectival triangulation to gather various perspectives on a phenomenon (see Ravitch & Carl, 2016). By using participants from more than one East African country, I was able to achieve perspectival triangulation. The participant pool was made up of participants from Eritrea, Ethiopia, Kenya, Rwanda, Somalia, Tanzania, and Uganda. The transcripts and audio recordings were secured for any further reviews throughout the data analysis process even after the transcripts had been uploaded to NVivo 12.

Confirmability

To achieve confirmability, I used self-reflection to assess personal identity, subjectivity, and positionality. By practicing self-reflection, I ensured that the data collected and analyzed were based on the responses of the participants. I monitored and documented personal perceptions and experiences and how they may have influenced any processes of the study, such as data collection, analysis, and interpretation of findings. Reflective journaling provided me with ongoing awareness of personal thoughts and feelings throughout the research process and ensured that the data collection and analysis

were not compromised by my preconceived ideas (see Ravitch & Carl, 2016). Awareness ensured that I focused on what the participants said rather than personal experiences and feelings that could cloud my judgment.

Results

This section of the chapter addresses the categories and themes that emerged from the data analysis as a response to the research questions. According to Creswell (2009), thematic analysis is one of the most common forms of data analysis used in qualitative research. During the thematic analysis, I looked for recurrences and vital words in the participants' responses. According to Ryan and Bernard (2003), recurrences and keywords are two techniques out of eight that assist in identifying themes during qualitative data analysis. Table 2 provides a brief outline of the 11 categories and three themes that came to light from the data analysis.

Table 2

Organization of Categories and Themes

Themes		
Perceptions of mental illness	Treatment of mental illness	Destigmatizing of mental illness
Categories		
Current definition of mental illness	Disclosing mental illness	Education and awareness
Past definition of mental illness	Healing practices in country of origin	Acceptance of mental illness
Causes of mental illness	Treating mental illness	Agencies and access
Causes of mental illness in country of origin	Mental illness stigma	

Thematic Analysis

This section provides an in-depth discussion of the 11 categories and three themes that were developed during the data analysis. As indicated in Table 2, the 11 categories were divided into three themes that allowed me to answer the two research questions. Each theme is discussed along with its corresponding categories.

Perceptions of Mental Illness

The first theme was perceptions of mental illness. This theme involved what the participants understood about mental illness. This theme emerged from answers to interview questions that asked the participants to define mental illness as well as to describe how mental illness is perceived in the participant's country of origin. Categories included current definition of mental illness, past definition of mental illness, causes of mental illness, and causes of mental illness in country of origin.

Current Definition of Mental Illness

All 12 participants responded to the interview question that asked for the definition of mental illness. All 12 of the participants indicated in their responses that mental illness is a condition that affects the brain and interferes with an individual's mental well-being and overall behavior and affects how the individual lives, socializes, and carries on with their daily life. All the participants mentioned illnesses such as schizophrenia and depression when asked for examples of mental illness. One participant further indicated that mental illness is "the breakdown in some hormones in the brain's chemical balance that leads to actions that are perceived to be outside the norm."

Past Definition of Mental Illness

Question one led to a follow up question that inquired whether the participants always defined mental illness the way they did in question one or whether this definition had changed over time. All 12 participants indicated that their definition of mental illness had changed since moving to the United States. One participant stated “prior to moving to the United States, I had no idea what mental illness was.” “I just remember hearing people saying those people are crazy or those are mad people.” All the participants indicated that there was never a clear definition of mental illness and illnesses like depression were not recognized.

Causes of Mental Illness

All 12 participants responded to the interview question, what do you think causes mental illness? Eight of the participants indicated that they believed mental illness is caused by genetics. The participants used phrases such as “I think a person can be born with it, or maybe genetics from their families.” In addition to genetics, four of the 12 participants also indicated that life experiences like trauma also contributed to mental illness. The participants used phrases such as “life experience, like a person going through trauma as a kid or as a teenager and then things come back like 10 years later.” Another participant stated “a person may have low confidence because of the way they were treated at home or at school by people who made fun of them.”

Causes of Mental Illness in Country of Origin

All 12 participants answered the question, what factors are presumed to cause mental illness in your country of origin? All 12 participants indicated that in their country

of origin, mental illness was associated with supernatural and ancestral spirits. One participant stated “I think the main one is someone casting a spell on them.” Another participant stated “the sickness is caused by juju or some kind of magic.” Four participants stated that the illness was often linked to witchcraft and used phrases like “people always think they have been bewitched.” One participant stated “mental illness is caused from generational curses because an individual’s ancestors did something wrong and now their spirits are demanding some sort of payment from the living family members.”

Treatment of Mental Illness

The second theme was treatment of mental illness. This theme involved how the participants believed mental illness should be treated as well as how mental illness is often treated in the participants’ countries of origin. This theme was formed from answers to questions that asked the participants how mental illness should be treated, how mental illness is often treated in East Africa, whether the participant would be comfortable telling family and friends that they had a mental illness, and how individuals with mental illness are perceived in the participant’s country of origin. Categories included healing practices in the country of origin, treating mental illness, disclosing mental illness, and mental illness stigma.

Healing Practices in Country of Origin

All participants responded to the question, how is mental illness often treated in your country of origin? All 12 participants indicated in their responses that healing practices of mental illness in their countries of origin often included taking the individual

to church. One participant stated “taking somebody to church regularly so that they are washed by the holy water.” Another participant stated “taking the person to monasteries or the family priest on a weekly basis for prayers.” One other participant stated, “mainly church and prayers because even if a person is Muslim, they still prayed for them in church hoping that they would recover.” In addition to prayers, all 12 participants also indicated that people were sometimes taken to the psychiatric hospitals. One participant stated “there are some cases where people would be taken to the psychiatric hospital, but there are limited resources for that.” Another participant stated “I think I have heard of the psychiatric hospital, but it almost feels like incarceration instead of being a place of rehabilitation.”

Treating Mental Illness

All 12 participants responded to the question; how do you think mental illness should be treated? Nine of the participants indicated that mental illness should be treated with therapy or medication. The participants used phrases like “I guess the way it can be treated is through therapy and medication.” One participant stated “it could be treated with therapy if let’s say there is a loss or depression, maybe they need to talk to someone who is a professional to figure their stuff out.” Three of the participants indicated that mental illness should be treated with compassion and acceptance. One participant stated “I think it should be accepted, especially in our community. I think it should be respected, whatever the person is going through, the person should be acknowledged even when it is considered not to be normal.”

Disclosing Mental Illness

All 12 participants answered the question, if you had a mental illness, would you be comfortable telling your family and friends? Why or why not? 10 participants had similar responses to this question indicating that they would be comfortable sharing with family and only close friends. One participant stated “I would definitely be comfortable to tell my close family and friends because they will be the ones who would be able to help me.” “But again, just telling random friends who are not that close, word can spread out and people can view you as different, so I would not share with everyone.” Another participant stated “absolutely, I just think that like with any other sickness, support matters.” Another participant stated “I do not want things that I can work on to be to my detriment, so if there’s a challenge, I would rather face it with those that love me, than by myself.” Two participants indicated that they would not be comfortable sharing with family but would be comfortable sharing with friends. One participant stated” I would not be comfortable telling my family because they would meddle.” The other participant stated, “I would not tell my family because, being the oldest, I have to stay strong for them, and I would not want to make them worry about me.”

Mental Illness Stigma

All 12 participants answered the question, how are individuals with mental illness often perceived in your country of origin? All participants indicated that mental illness and individuals with mental illness are often stigmatized. One participant stated “I remember when I was in Rwanda, one of my neighbors had a mental breakdown and the family did not want to go the neighborhood psychiatric clinic because they did not want

the neighbors to know that their family member had a mental illness because they believed that people would laugh at them." Another participant stated "in the city that I was in, there was one mental health hospital and anybody who was seen there was called crazy even if they were there to talk about depression or about life or just walking through the door, you would hear people in the neighborhood describing the person as being crazy." All participants indicated that people with mental illness are often shunned from society or shushed away. One participant stated "when you know that someone has mental illness, you are told not to play with that person because you do not want to become like them."

Destigmatizing Mental Illness

The third theme was destigmatizing mental illness. This theme involved what the participants believed contributed to the changes in their perception of mental illness. This theme was formed from answers to questions that asked the participants whether there had been changes to the participant's perception of mental illness since moving to the United States, what the participants believe led to the changes in their perception, and knowledge about mental health services in the participants' countries of origin and current city of residence. Categories included education and awareness, acceptance of mental illness, and agencies and access.

Education and Awareness

All 12 participants answered the question, has your perception of mental illness changed since being in the United States? Why or why not? All participants responded yes to this question. All the participants indicated that increased education and awareness

about mental illness contributed to the change in their perception of mental illness. One participant stated “being able to put a name on the different kinds of mental illness instead of labeling everything and everyone as crazy as is the case back home has been helpful.” Another participant stated “I used to think that only people with pre-existing factors are the only ones who got mental illness, but I now know that anybody can go through depression or stress pretty quickly.” The theme of education and awareness was also recurring in responses to the question, if there was one thing that you wish you knew while growing up that would get you to your current perception of mental illness, what would it be and why? Participants indicated that early education and awareness about mental illness would have made a difference in understanding mental illness especially the effects of stigma.

Acceptance of Mental Illness

All participants responded to the question, what cultural, social, and religious experiences if any, do you believe contribute/contributed to your perception of mental illness? All participants indicated that acceptance of mental illness in the United States was a major factor in perception of mental illness. One participant stated “although there is still some stigma in the United States, there is more acceptance than back home.” Another participant stated “people with mental illness are not shunned, rather policies are put in place to help them remain productive members of society.” Eight participants indicated that seeing celebrities such as Oprah, Demi Lavato, and Michael Phelps embrace and talk about mental illness openly contributed to the participants’ perceptions of mental illness.

Agencies and Access

All participants responded to the question, do you have knowledge about any mental health services in your country of origin and in your current city? All 12 participants indicated that they knew about at least one psychiatric hospital in their countries of origin and nothing else. Two participants further indicated knowledge of an additional private practice where individuals could receive mental health services. All participants indicated knowledge of mental health services and agencies in their current city of residence. One participant stated "I know that I can call 211 and they will tell me where to go." Another one stated "my workplace provides us with mental health services." Five participants indicated knowledge of the national mental health help line and two participants mentioned knowledge of the 24-hour access and crisis lines in their cities.

Summary

Chapter 4 described the demographics, settings, data analysis, thematic analyses, and evidence of trustworthiness. In addition, Chapter 4 showed the detailed data collection and data analysis procedures. After conducting the interviews, listening to the audio, transcribing the audio, and reviewing the transcripts, I developed a better understanding of East African immigrants' perception and interpretation of mental illness. At the end of the coding process, 11 categories and three themes emerged to support the two research questions. All the participants had an idea of what mental illness was and had a clear understanding about the causes of mental illness. All the participants indicated that their definition of mental illness had changed over time after immigrating

to the United States. Additionally, all the participants indicated that their perception of mental illness had also changed since immigrating from East Africa to the United States. Most of the participants indicated that they became more accepting of individuals with mental illness and believed that mental illness must be treated with compassion like any other illness. The participants noted that increased awareness and education on the causes of mental illness as well as proper treatment contributed to their understanding and acceptance of individuals with mental illness. The participants' responses also indicated that increased mental health services are needed in East Africa. Additionally, the participants indicated that mental illness stigma and the negative perception about individuals with mental illness is a significant barrier to seeking help for mental illness from a mental health professional and from reaching out to family and friends. Chapter 5 demonstrates the relationship between the categories and themes and the literature review presented in Chapter 2. Additionally, Chapter 5 contains the current study' findings, implications for social change, limitations, and recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative phenomenological study was to explore how East African immigrants in the United States perceived and interpreted mental illness as a result of lived experiences. A sample of 12 East African immigrants across the United States participated in the study. The purpose of the study was to gain greater insight into East African immigrants' lived experiences and the impact of those experiences on the participant's perception and understanding of mental illness. I analyzed the interview data to identify themes that I used to guide the interpretation and discussion of findings. The study's findings revealed three themes and 11 categories that offered deep insight into the cultural perception of mental illness among East African immigrants in the United States and how these perceptions contribute to the acceptance of mental illness.

The current chapter provides a comprehensive discussion of the study's findings, which includes the themes and categories that emerged from the research questions; an explanation of the interpretation of the findings; and a description of how the findings relate to current literature. I also clarify the limitations of the study, offer recommendations for further research, and identify implications for social change.

Interpretation of the Findings

The findings of this study confirmed and extended the findings in the literature reviewed in Chapter 2. Previous research indicated the stigma experienced by individuals with mental illness in East Africa. The current study showed that more education and awareness is needed in East Africa to break down the stigma that surrounds mental illness. The current findings highlighted important information regarding the perception

and interpretation of mental illness among East African immigrants in the United States. The literature review demonstrated the prevalence of mental illness in East Africa. However, there was not much knowledge about how a different environment or culture changes the perception of mental illness among East African immigrants. In Chapter 2, I demonstrated that there was a high rate of mental illness stigma in East Africa and that individuals with mental illness are often kept in isolation and considered a shame by the community and family members (see Atilola, 2016) in contrast to how mental illness is seen and managed in the United States.

The categories and themes that emerged from the data analysis are consistent with the literature that is presented in Chapter 2. The three themes that emerged included perceptions of mental illness, treatment of mental illness, and destigmatizing mental illness. The results of the study contributed to existing information and also began to fill the gap in research regarding the impact of social and cultural experiences of East African immigrants in the United States and how those experiences influence the perception of mental illness. The contribution to existing literature was achieved by the study's identification of the negative effects of mental illness stigma on both individuals and communities in East Africa. The study's findings filled a gap in the literature by providing information on likely contributing factors to changes in perception of mental illness among East African immigrants in the United States.

Bandura's (1997) social learning theory and Berry's (2007) acculturation model provided the theoretical framework for this study. As described in Chapter 2, social learning theory and Berry's acculturation model provided a framework for explaining the

changes in the perception of mental illness among East African immigrants in the United States. The social learning theory offers an explanation of how individuals learn behavior from others (Bandura, 1997). Berry's model of acculturation offers an explanation of the understanding of acculturation strategies that individuals use to navigate a new culture. The emerging themes of the current study are addressed in the following section: (a) perceptions of mental illness, (b) treatment of mental illness, and (c) destigmatizing mental illness.

Perceptions of Mental Illness

The first theme, perceptions of mental illness, was further categorized as past definition of mental illness, current definition of mental illness, causes of mental illness, and causes of mental illness in country of origin. This theme and categories reflected the participants' past and present understanding of not only what mental illness is but also what causes mental illness. This theme and categories also covered any experiences that led to the changes in the definition of mental illness and causes of mental illness.

All 12 participants responded to the question that asked about the definition of mental illness. One participant stated "mental illness is caused by a chemical imbalance in the brain and included illness such as schizophrenia." The other participants provided definitions that indicated that mental illness is a disease of the brain or a person's mental state. Because I sought to understand the experiences of East African immigrants and perceptions of mental illness, I asked whether the definition of mental illness that the participants provided was similar to the definition the participant had prior to migrating to the United States. All 12 participants indicated that the definition of mental illness had

changed since migrating to the United States. One participant stated “before I moved to the United States, I had no idea what mental illness was. I just thought that the person was bewitched.” Another participant stated “mental illness was not even in my vocabulary. People who acted different were only referred to as crazy. That is all we knew.”

When asked what contributed to the changes in the definition of mental illness, all participants provided responses that echoed the mental health culture in the United States as a contributing factor. One participant stated “understanding that anyone can develop a mental illness and that mental illness does not have to be severe in nature expanded my definition of mental illness.” Several participants echoed this statement by indicating that mental illness does not have to be accompanied by mania and hallucinations but that things such as social withdrawal can be indicative of a mental illness. This is something that was not portrayed in East Africa. The participants indicated that exposure to a different culture helped broaden their perspectives of mental illness.

The participants also responded to questions that addressed what causes mental illness and what is believed to cause mental illness in East Africa. All 12 participants responded to the questions. One participant stated “just life in general can cause mental illness….It is tough to balance all the challenges that come with life and that can cause depression.” Another participant stated “trauma can cause mental illness.” This was echoed by other participants who indicated that acts of violence such as wars, assaults, and domestic violence can contribute to mental illness. This, however, was not the case in East Africa as shared by the participants. One participant stated “in Tanzania, mental

illness is associated with evil spirits because it is looked at as a punishment." Another participant stated "in Somalia, mental illness is associated with a family's ancestors and therefore people who get mental illness are believed to have angered the ancestors." As with the definition of mental illness, the participants indicated that living in the United States and being exposed to a different culture regarding mental illness contributed to recognizing the real causes of mental illness and understanding that often the individual with mental illness has nothing to do with it.

This theme is consistent with Berry's (2007) acculturation theory, which provides an understanding of acculturation strategies that individuals use to navigate a new culture. The participants in the current study shared similar reasons for the changes in the perceptions of mental illness with one of the most common reason being the adoption of the American cultural attitude toward mental illness. The theme is also consistent with Bandura's (1977) social learning theory, which indicates that individuals learn new behavior from observing others and modeling their behavior. The theme is further reinforced by previous research that addressed the perceptions people from other cultures had regarding mental health and mental illness and the unique coping mechanisms they used based on their cultural beliefs and values (see Dow, 2011). According to Dow (2011), the perceptions people had regarding mental illness and the unique coping techniques used were often based on cultural beliefs and values.

The current study's findings also provided an extension to the existing literature. According to Amuyunzu-Nyamongo (2013), in Africa causes of mental illness were associated with evil spirits and witchcraft. This was something that was echoed by the

participants in the current study. Amuyunzu-Nyamongo (2013), also noted that individuals with mental illness were often treated in shrines by traditional healers or witch doctors. The current participants echoed this finding by sharing that individuals with mental illness were often treated in traditional health centers rather than in the available mental health hospitals.

This current findings also corroborated previous research regarding what immigrant populations often experienced in adjusting to the host culture. According to Hong et al. (2014), an individual's nativity status played a major role in the mental health of ethnic and racially minority groups, more specifically what mental health and illness were considered to be. The participants in the current study reported that the meaning of mental illness was dictated by the culture and beliefs in the country of origin and later by the practices and beliefs in the United States. As shown by Huang et al. (2011), integrating and imitating the mental health practices in the United States were shown to adjust the perceptions of mental illness among Latina and Asian American women.

Treatment of Mental Illness

Treatment of mental illness was the second theme. This theme was developed from data related to treatment practices for mental illness in East Africa, disclosing mental illness, treatment of mental illness, and mental illness stigma in East Africa. The participants shared perceptions of mental illness as well as how mental illness was treated in East Africa. Additionally, the participants shared how mental illness should be treated. This theme reflected the participants' experiences regarding how individuals with mental illness were treated in East Africa as well as the stigma that individuals with mental

illness faced. A participant from Rwanda stated “I remember a neighbor of mine who had a mental illness and my parents asking me not to play with him.” Another participant stated “there was only one psychiatric hospital and anyone who was seen entering that hospital was assumed to be crazy and we were instructed to avoid them.”

The participants’ indicated that unlike in East Africa where individuals with mental illness were often referred to as crazy and shunned from society, they should be treated with compassion and by a mental health professional, as is often the case in the United States. One participant stated “it is nice to see families and communities stand by individuals who are struggling with mental illness instead of locking them up in a bedroom or sending them to the village.” Another participant stated “after seeing my brother’s friends visit him during his episodes of bipolar, I realized that it is ok to get close to someone with mental illness.” A participant from Kenya stated “when I was struggling with depression, I did not realize how much help there was until my coworkers encouraged me to seek help.” This participant further stated “I did not know that I had depression. I just thought I was being lazy and weak. Going to see a mental health profession helped me understand that I had depression.” All participants echoed that being in a culture that was more open and less judgmental about mental illness helped change their perceptions of mental illness. This is consistent with Bandura’s (1997) social learning in which individuals learn by imitating others. The participants in the current study reported learning the proper way to treat mental illness by observing how peers, families, and communities in the United States treated individuals with mental illness.

Despite all of the confirming findings in the study, there were some statements made by participants that indicated that living in the United States did not influence their perception of mental illness. One participant from Ethiopia indicated that her parents had lived in the United States for more than 2 decades and they still believed in traditional methods of treating mental illness. The participant stated "when my brother showed signs of schizophrenia, my parents sent him to Ethiopia for 1 year because they believed the ancestors wanted to meet him." The participant further shared that after a year of traditional treatments, she was able to convince her parents to bring back her brother because there was no difference in his symptoms. This is a representation of individuals not imitating what they see. According to Bandura (1977), not all observed behavior will be learned. This finding also fits with the separation strategy in Berry's (2007) acculturation model. In the separation strategy, individuals value their heritage culture and do not want to learn the new culture. A few current participants reported that the older generation of East African immigrants such as parents and grandparents still sometimes struggled with giving up the traditions of treating mental illness, often wanted to try the old ways, and failed before trying Western treatments.

These findings affirmed earlier research findings that individuals with mental illness in East Africa face severe stigma and isolation (see Atilola, 2016). In Atilola's (2016) study, 10 of the participants indicated witnessing individuals with mental illness being stigmatized by families, friends, and communities. The participants indicated seeing individuals with mental illness referred to as crazy and made to stay in insolation away from other members of the community. Because of this, individuals with mental

illness were often taken to church or traditional health centers by family members to protect the rest of the family from stigma (Atilola, 2016). When asked how religion plays a factor in mental illness treatment, one participant in the current study stated “although religion plays a part in how mental illness is viewed in America, I have heard my pastor encourage people to seek treatment from mental health professionals in addition to prayer.” Several current participants reported that the churches they have been associated with in the United States embrace mental illness and encourage individuals to seek treatment from mental health professionals.

Destigmatizing Mental Illness

The third theme was destigmatizing mental illness. This theme included education and awareness, acceptance of mental illness, and agencies and access. All participants indicated that a step toward destigmatizing mental illness involved increased education about mental illness. The participants indicated that increased education and awareness about mental illness in the United States through outlets such as television advertisements and work programs contributed to the participants’ positive attitude toward mental illness. This theme is consistent with social learning theory and Berry’s (2007) acculturation model. One participant stated “if I had school counselors to guide me on school rather than teachers calling me crazy every time I acted out, I would be a completely different person.” Early education about mental illness was reported by several participants as the one way to reduce mental illness stigma as was the case in the United States.

This theme also extended the existing literature. According to Monteiro (2015), increasing mental health awareness and improving the existing mental health services will contribute to understanding of mental illness and mental health as a whole. As a result, this can reduce the stigma associated with mental illness. This sentiment was echoed by the participants in the current study. All participants indicated that early education and awareness coupled with easy access to mental health services was a good way to reduce mental illness stigma. One participant stated "if I had been taught everything I know now while I was in primary or even secondary school, I would never have feared people who had mental illness."

A majority of the participants indicated that the availability of mental health services in the United States made it easier to access the services. One participant stated "you can almost always access mental health services everywhere you go like in school, at work, or hospital." Another participant stated "it is helpful to have several crisis lines that are available around the clock because it takes away the stigma that might come with actually going into a clinic." The participant further stated "if this was available in Uganda, many people would be getting the help that they needed without the fear of being alienated by their friends and family." Additionally, the willingness of people to use the available mental health services in the United States encouraged the participants to openly use mental health services for themselves. Two participants indicated that they had witnessed individuals that they admired acknowledge that they received mental health services when they were struggling with personal issues. "One participant stated "my supervisor whom I admire and believe to be the strongest man I know once shared

during a company meeting that he took time off to deal with chronic stress and depression." The participant further stated "this was really eye-opening because I would never think that he has had such struggles and I now have no shame seeking mental health services for myself." This behavior is supported by Berry's (2007) acculturation model which accounts for an individual's willingness to practice the host's beliefs and norms under assimilation and integration strategies.

According to Huang et al. (2011), immigrants who used assimilation and integration were more likely to utilize general health and mental health services compared to those who chose the separation strategy. Using separation means that an individual prefers to maintain the practices of their heritage culture and do not use or copy the practices of the host culture (Berry, 2007). The results of the study indicated that all the participants used the assimilation and integration strategy as indicated by the responses to the question, how do you think mental illness should be treated? All participants indicated that mental illness needs to be treated by a mental health professional or proper medication and intervention methods like therapy. However, the responses to the question, if you had a mental illness, would you be comfortable telling your friends and family indicated that some East African immigrants use the separation strategy. A few of the participants indicated that sharing their mental illness with friends and family would not be an option. They reported that some family members do not accept Western treatments and would ask the sick individual to practice traditional treatments rather than Western practices.

The results of the study also indicated that having a variety of services to accommodate an individual's specific needs contributed to the willingness of the participants to seek mental health services. One participant stated "having specific places for individuals struggling with specific issues like depression, addiction, or grief makes it easy to seek help." This was echoed by other participants who stated "having one psychiatric hospital in which every mental illness is treated, as is the case in most East African countries makes it difficult for individuals to seek help." The negativity associated with the psychiatric hospitals also made individuals with mental illness hesitant to seek proper treatment (see Mantovani et al., 2017). According to Knettel et al. (2018), although mental illness stigma is still a major problem in East Africa, education and awareness will enable individuals see the value of Western treatments such as therapy and psychiatric medication. Additionally, once more people begin to use Western treatments others will follow along as people often learn behaviors from each other (see Knettel et al., 2018).

Like any other study, the results of the current study do not guarantee applicability to everyone. Furthermore, every study has a scope or boundaries within which it operates. Specific criteria are put in place to ensure that the participants will make meaningful additions to what is being studied. Because the current study followed specific criteria during sampling and data collection, there are some limitations as will be discussed.

Limitations of the Study

One limitation of the current study is that the findings cannot be generalized to all East African immigrants in the United States because of the limited sample size of 12 participants. Although 12 is an adequate sample size for a qualitative study, it does not reflect the entire East African immigrant population in the United States. The data from the small sample may therefore limit dependability and transferability despite participant variation. The current study also excluded individuals who did not speak English and therefore possibly missed out on potential participants who spoke other languages. Additionally, due to the COVID 19 pandemic, the current study was conducted via Zoom and therefore participants who had no access to the internet could not participate in the study. Internet instability also affected the interviews because there was some interference during some interviews that may have affected the quality of the data that was collected.

Recommendations

The findings of the current study may act as a launch for future qualitative and quantitative research on individuals' experiences and perceptions of mental illness. New qualitative studies could explore experiences of East African immigrants in other Western countries to gain additional information and knowledge about the lived experiences and perceptions of mental illness in their countries of residence. Improving understanding of the factors involved in changing people's perceptions of mental illness could increase the pool of knowledge that can contribute to the improvement of mental health services for East African immigrants. Additional studies could further account for

the participants' socioeconomic status and education level that was not accounted for in this study. According to Jenkins et al. (2012), individuals with higher socioeconomic status are more likely to access and utilize mental health services than individuals from a low socioeconomic status. Furthermore, individuals who had gone beyond secondary school education were more open to discussions about mental illness (see Jenkins et al., 2012).

Using focus group discussions is also recommended. Focus group discussions may provide the opportunity for individuals to think about things that might not come up during individual interviews (Laureate Education, 2016a). Focus group discussions may also offer a bigger platform for discussion of ideas especially when it comes to identifying strategies that can be implemented to help destigmatize mental illness in East Africa (Laureate Education, 2016a). With a good moderator, focus group discussions can be an excellent source of information from which future research may benefit (Laureate Education, 2016a).

Implications

The current study's results contributed to filling the gap in professional literature on the topic of lived experiences of East African immigrants and their perceptions of mental illness. The current study's results can be used to increase cultural sensitivity and awareness among mental health providers working with East African immigrants and thereby contributing to social change. Cultural sensitivity is important because it helps mental health providers understand some of the push back and hesitation that might be expressed by the immigrant clients with whom they work (Omenka et al.,2020).

Shedding light on the lived experiences of East African immigrants and the impacts of these experiences on perceptions of mental illness allowed me to identify gaps in the availability of and access to mental health resources in East Africa and in the East African communities in the United States. Additionally, the current study could possibly increase knowledge and awareness of the dangers of mental illness stigma, as well as the benefits of mental health education, treatment, and acceptance of mental illness. This can be achieved by sharing the results of the current study with policy makers, mental health providers, community organizers, and community members. The results of the study could also be shared during trainings on mental health awareness and cultural diversity to increase the impact on social change.

The current study's results could help provide a framework for future curricula and education on mental illness stigma and its effects on the individual, families, and communities. This can be achieved by using the current study's results to provide knowledge on specific topics that the audience could benefit from including the reasons why individuals with mental illness are not always comfortable sharing their conditions with friends and family. The results of the current study could provide mental health providers with useful information to assist East African immigrants who may be struggling with mental illness and are afraid to seek help by providing the tools and knowledge needed to work with individuals who are afraid of being stigmatized. Additionally, the findings of the current study could serve as a starting point for more qualitative and quantitative research as there is not enough literature and data on the topic. Having more research and data can contribute to much needed policy changes.

Future studies could include non-East African immigrant populations, as mental illness stigma is highly prevalent across Africa (Monteiro, 2015).

Conclusion

I sought to understand the lived experiences of East African immigrants in the United States and the impact of these experiences on their perceptions of mental illness. The exploratory approach with a phenomenological method allowed me to gain a deep understanding of the perceptions and interpretation of mental illness among East African immigrants in the United States. According to NAMI (2017), a mental health system supports individuals who suffer from mental illness in improving their quality of life by providing treatment that helps recover abilities, hopes, and dreams that are affected by the mental illness. NAMI (2017) further indicated that untreated mental illness can impede an individual's quality of life.

WHO (2017,) reported that 1 in 4 people in East Africa suffers from a mental illness. However, a study conducted by Corrigan et al. (2014), indicated that less than 5% of individuals with mental illness access and receive appropriate mental health services. For East African immigrants who receive mental health services, the services may be culturally inappropriate because of a lack of historical and cultural understanding (Elo et al., 2015). The current study is important for mental health research, as there was a deficiency of literature on the topic of perceptions of mental illness of East African immigrants in the United States. Additionally, the background literature showed that there is a high prevalence of mental illness and mental illness stigma in East Africa and in the United States. The hope is that the knowledge and understanding from the current

study may bridge the gap in literature and treatment of East African immigrants in the United States.

It is important to share the outcome of the current study with the East African immigrant community as well as mental health providers because it can potentially positively influence individuals to seek help for mental illness from mental health providers and mental health agencies. The information shared by the participants may allow other East African immigrants and community members to understand that others share their perceptions, thoughts, feelings, and interpretations about mental illness. This information may also provide an avenue for the entire East African community to begin conversations with each other regarding mental health needs. An important theme that emerged from the data analysis indicated that East African immigrants are open to acceptance of mental illness and to receiving treatment from mental health professionals. This information is useful in implementing mental health services in East Africa as well as encouraging East African immigrants who may be hesitant to seek professional help to do so.

Furthermore, after reviewing the results of the current study, I was more enlightened by the East African immigrant community's receptiveness and eagerness to learn more about mental illness and mental health in general. The inability of individuals with mental illness to access and receive mental health services is attributed to mental illness stigma and inadequate knowledge and understanding of any available mental health services rather than a lack of interest in needing help. The East African immigrant community is aware of the challenges related to mental illness in East Africa as well as in

the United States, however the lack of information makes it difficult to navigate the mental health systems. The results of the current study allowed the researcher to find out and share existing challenges with policy makers and stakeholders. The hope is that the shared experiences of the participants will be a foundation for not only future research, but also for providing feedback to clinicians, communities, and agencies.

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Appendix A: Recruitment Flyer

RESEARCH PARTICIPANTS NEEDED

Between the ages of 20 and 65, born and raised in East Africa, and lived in the United States for more than two consecutive years? Have you heard of mental illness? Do you know anyone with mental illness? Do you have any kind of experience or association with mental illness?

If you meet the criteria above, you are invited to participate in a research study to explore the experiences of East African immigrants and their perceptions of mental illness. This research study will be conducted by Marion Pickering, Walden University's Doctoral Student in the School of Psychology under the College of Social and Behavioral Sciences. This endeavor is a part of her requirement towards earning a doctorate in Clinical Psychology. The study involves a one to two hour in-depth face to face or video individual interview and a two to three hour focus group discussion about your perceptions around mental illness.

For further information regarding this study, please contact Marion Pickering

Appendix B: Interview Questions

Introduction

I am extremely interested in your perceptions on the topic of mental illness. I am interested in your experiences both in East Africa and in the United States. I am mostly interested in any significant changes that may have occurred to your perceptions of mental illness while living in the United States and what you believe led to those changes. There are not "right" or "wrong" answers to these interview questions and every response will be appreciated.

1. What do you perceive to be the definition of mental illness?
2. What do you think causes mental illness?
3. How do you think mental illness should be treated?
4. How do you view people with mental illness?
5. If you know of someone who has a mental illness, what kind of treatment would you recommend to them?
6. If you had a mental illness, would you be comfortable telling your family and friends? Why or why not?
7. How is mental illness understood in your country of origin?
8. What factors are presumed to cause mental illness in your country of origin?
9. How are individuals with mental illness often described in your country of origin?
10. What are some of the healing practices for mental illness in your country of origin?
11. Do you think mental illness can be successfully treated?

12. Would you encourage someone with a mental illness to seek help from a mental health professional?
13. What cultural, social, and religious experiences if any, do you believe contribute to your perception of mental illness in the past and present?
14. Has your perception of mental illness changed since being in the United States? Why or why not?
15. Do you have any knowledge about mental health services in your country of origin and in your current city?
16. If there was one thing that you wish you knew while growing up that would get you to your current perception of mental illness, what would it be and why?

Appendix C: Demographic Survey

These questions are developed to gather demographic information about the participants.

1). Age

a. 20-30

b. 31-40

c. 41-50

d. 51-60

e. 61 and above

2). Gender

a. Male

b. Female

c. Other (specify)

3). Country of origin

a. Burundi
b. Comoros
c. Djibouti
d. Eritrea
e. Ethiopia
f. Kenya
g. Madagascar
h. Malawi
i. Mayotte
k. Mozambique
l. Reunion
m. Rwanda
n. Seychelles
o. Somalia
p. Southern Sudan
q. Tanzania
r. Uganda
s. Zambia

j. Mauritius t. Zimbabwe

4). Year you immigrated to the United the States

a. Before 1970

b. 1970-1980

c. 1981-1990

d. 1991-2000

e. 2001-2010

f. 2011-2018

5). Religion

a. Catholic

b. Protestant

c. Muslim

d. Seventh Day

e. Jehovah's witness

f. Born Again

g. Other (Specify)

6). Profession

a. Education

b. Medical

c. Social services

d. Technology

e. Hospitality

f. Other (Specify)

Appendix D: Interview Schedule

Participant Name	**Date**	**Time**
PRSHA1	Sunday 01/10/2021	2pm PST
PREMK2	Tuesday 01/12/2021	6pm PST
PRUAL3	Friday 01/15/2021	7pm CST
PREWT4	Monday 01/18/2021	1pm EST
PRKAK5	Saturday 01/23/2021	10am PST
PRRKD6	Sunday 01/24/2021	3pm EST
PRRUN7	Tuesday 01/26/2021	9pm PST
PRTSK8	Wednesday 01/27/2021	7pm EST
PRTAW9	Wednesday 01/27/2021	5pm PST
PRKVB10	Friday 01/29/2021	5pm EST
PRKSM11	Monday 02/01/2021	6pm PST
PRUOJ12	Tuesday 02/02/2021	3pm PST