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Sub-Saharan African Immigrants' Experiences in Utilizing Mental Health Services in Baltimore

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Abstract

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Dissertation Submitted in Partial Fulfillment

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Abstract

Mental illness is associated with poor quality of life evidenced by unemployment, homelessness, and substance abuse. Despite the adverse effects of mental illness, research has indicated that mental health-seeking behaviors and experiences in accessing mental health services among immigrants from sub-Saharan Africa are under-researched. The purpose of this qualitative study was to explore the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore, Maryland. To achieve the objective of this study, a descriptive research study was conducted utilizing semistructured one-on-one in-depth interviews with eight sub-Saharan African immigrants in Baltimore. Braun and Clarke's six-step thematic data analysis approach was adopted resulting in five main findings. The study findings indicated the following: (a) stereotyped beliefs about mental health contributed to poor health-seeking behaviors among immigrants from sub-Saharan Africa, (b) there is limited mental health knowledge among sub-Saharan African immigrants, (c) low-income levels and lack of health insurance limit immigrants' access to mental health services, (d) undocumented immigrants lack access to mental health services due to fear of deportation, and (e) low English language proficiency among immigrants limits access to mental health services. From the findings, it is plausible to conclude that sub-Saharan African immigrants face diverse challenges that hinder access to mental health services. The findings may bring about positive social change by improving the mental health outcomes and service utilization among sub-Saharan African immigrant populations.

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Dedication

I am dedicating my dissertation to my beloved parents William Achu and Susanna Achu who meant and continued to mean so much to me. Although they are no longer of this world, their memories continue to regulate my life. First and foremost, to my father William Achu whose love for me knew no bounds and, who taught me the value of hard work. Thank you so much dad, I will never forget you. To my mother Susanna Achu I say this “gone away from our loving eyes left a void never to be filled in our lives”. Although your life was brutally made short, I will make sure your memory lives on as long as I shall live. I love you all and miss you all beyond words. Rest in perfect peace.

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Chapter 1: Introduction to the Study

Out of the 40 million immigrants in the United States, marginally more than 2 million are from sub-Saharan Africa (Fazel-Zarandi et al., 2018). While this population remains small, representing just 4.5% of the country's 40 million immigrants, it is a rapidly growing population. As a result, the mental health concerns of sub-Saharan African immigrants have implications for the overall health of the U.S. population. Further, diverse and culturally oriented social stigmas involving the utilization of mental health services deter sub-Saharan African immigrants from reporting mental conditions and from utilizing mental healthcare services (McCann et al., 2018). African immigrants are susceptible to assumptions of criminality, social exclusion, and social discrimination, which influence their willingness to access and utilize mental health services (McCann et al., 2018). The focus of this qualitative study was to explore the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore, Maryland. The basis for conducting this study was to assess the unique experiences of sub-Saharan African immigrants in the United States, as their numbers are increasing rapidly.

Social inferences for understanding the cultural principles of sub-Saharan African immigrants entail how to better comprehend their mental health service utilization and barriers. The current study was important for practice because new information concerning sub-Saharan African perceptions of access to mental health services in Baltimore is needed. Practitioners in Baltimore may find that these perceptions aid in an assessment of how to improve access and use among these populations. The objective of Chapter 1 is to put the research theme in perspective. I provide a general overview and

authentication of the study in this chapter. Various sections are included in this chapter: the background of the study, problem statement, purpose of the study, research question, theoretical orientation, nature of the study, assumptions, scope and delimitations, limitations, significance, and summary.

Background

The mental health of sub-Saharan African immigrants in the United States is a largely under-studied subject, despite the rapidly growing size of this population and its uniqueness. There are approximately 40 million immigrants in the United States (Fazel-Zarandi et al., 2018). Of these, slightly more than 2 million are from sub-Saharan Africa (Fazel-Zarandi et al., 2018). While this population remains small, representing just 4.5% of the country's 40 million immigrants, it is growing rapidly. Therefore, their mental health concerns have implications for the overall health of the nation. Factors leading to the migration of sub-Saharan Africans to the United States comprise education, political disturbances in their countries of origin, and family reunification, as well as other aspects such as brain drain and diversity lottery program (Omenka et al., 2020). For example, numerous African nurses and doctors move to the United States for higher-paying prospects, leaving behind decrepit medical systems in their origin nations (Omenka et al., 2020). The mental health needs and experiences of Africans, particularly sub-Saharan African immigrants, are not collective, and studies have indicated that there is a significant disparity in mental health experiences across diverse groups from this population (McCann et al., 2018; Omenka et al., 2020). Factors such as employment, marital status, gender, and alcohol consumption significantly influence the mental health

of sub-Saharan African immigrants in the United States (Ayele et al., 2020; Escamilla & Saasa, 2020).

Previous researchers have sought to explore the mental health experiences of sub-Saharan African immigrants in the United States, with a focus ranging from factors linked to mental health service use to the overall experiences of this population while accessing mental health care. Ayele et al. (2020) examined the factors linked to mental health service use by Ethiopian immigrants and refugees in the United States. The researchers employed a cross-sectional survey based on Andersen's model of health services to collect research information from 297 Ethiopian immigrants and refugees in the United States between February and March 2018. The collected data were analyzed using descriptive statistics, logistic regression, and chi-squared tests. The findings revealed that about 17.3% of the respondents sought mental health services from nonhealthcare experts, while 13.3% used healthcare professionals for mental health concerns. The researchers identified a need for mental healthcare. A model comprising predictors of the utilization of mental health services was statistically significant, with employment, marital status, and gender as the strongest predictors (Ayele et al., 2020). Based on these findings, Ayele et al. suggested the need for the establishment of culturally suitable interventions and the adoption of policies to reduce barriers to mental healthcare services among Ethiopian immigrants.

In addition, Escamilla and Saasa (2020) similarly indicated that gender influences mental health and mental health service utilization among African immigrants in the United States. The findings indicated that men were more likely to show increased

depression and anxiety symptoms. However, unlike in the study conducted by Ayele et al. (2020), income and marital status did impact these mental health symptoms. Escamilla and Saasa suggested that there is a further need to understand male African immigrants in the United States and both the external and internal factors that impact these mental health variables. Escamilla and Saasa's study was significant to this study as it demonstrated the increased mental health risk among African male immigrants in the United States. Also, they demonstrated a gap in the quantitative approach, which limits the descriptive understanding from a qualitative approach. For the current study, I utilized a qualitative approach to fill this identified gap.

The stigma of substance misuse and mental illness can deter help-seeking, particularly in immigrants who are usually reluctant to look for help early for these concerns (McCann et al., 2018). Self-stigma and public stigma are typical among this population of sub-Saharan African immigrants and deter help-seeking behaviors within the sub-Saharan African immigrant community (McCann et al., 2018). These findings are important to the study as they demonstrated the difficulty of sub-Saharan African struggles with mental health as well as recommendations for further research.

Research has established that health-seeking behavior among sub-Saharan Africans is reduced due to sociocultural differences and the general complexity of the immigration process (Fanfan & Stacciarini, 2020; Haffizulla et al., 2020; Louis et al., 2017). Past assessments are largely quantitative, which, though useful, do not provide a descriptive assessment based on the experiences of these specific individuals (Ayele et al., 2020; Escamilla & Saasa, 2020). However, there is a lack of research that examines

the experiences of sub-Saharan African immigrants in accessing mental health services. Although researchers have investigated this issue, the topic has not been explored regarding the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore. The current study addressed this gap by identifying information specific to this population and detailing their experiences with accessing mental health services.

Problem Statement

Sub-Saharan African immigrants are a growing population in the United States. Social exclusion increases worries regarding one's safety, subjection isolation, anxiety symptoms, depression, and decreased societal trust among African immigrants (Saasa et al., 2021a). There is a need for social work interventions, which target discrimination and structural exclusionary approaches in efforts to enhance the social well-being and mental health of African immigrants in the United States, yet there are many barriers to this population in regard to seeking support. Ayele et al. (2020) identified the existence of barriers to mental health services among Ethiopian immigrants in the United States. The strongest predictors of mental health care use among Ethiopian immigrants in the United States include employment, marital status, and gender (McCann et al., 2018). In addition, Saasa et al. (2021a) found that men are more likely to show increased depression and anxiety symptoms in a study targeting second-generation immigrants from African countries, suggesting that gender impacts mental health and utilization of mental health services among African immigrants in the United States.

The cause of the under-utilization of mental health services among African immigrants is likely rooted in the stigma surrounding mental illness. Self-stigma and public stigma are typical and have been found to deter help-seeking behaviors among sub-Saharan African immigrants (McCann et al., 2018). Most African immigrants possess cultural principles that influence their opinions of mental illness, which are distinctively diverse from normative American views, interventions, and resources (Amoako & MacEachen, 2021). Employment, marital status, and gender are the key barriers to mental health access among African immigrants in the United States (Ayele et al., 2020), and gender deters African immigrants from seeking mental health services (Escamilla & Saasa, 2020).

Subsequently, African men face differing challenges in terms of health, resources, and access to educational opportunities. As a result, the integration process within a new society after immigration is a difficult process for sub-Saharan African men (Malika et al., 2020). The access process for mental health care among African men is often characterized by fear of stigma, social and cultural preferences, as well as lack of help-seeking behavior due to gender roles within their own culture (Fanfan & Stacciarini, 2020; Haffizulla et al., 2020; Louis et al., 2017). The problem is the lack of mental health service utilization and barriers to mental health care among the sub-Saharan African immigrant population as well as the diverse barriers to accessing mental health services (Ayele et al., 2020; Escamilla & Saasa, 2020; McCann et al., 2018; Pannetier et al., 2017; Saasa et al., 2021a, 2021b; Vigod et al., 2017).

Various scholars have suggested the need to conduct further research on the experiences of sub-Saharan African immigrants in the United States regarding mental health utilization and barriers (Ayele et al., 2020; Escamilla & Saasa, 2020). The findings of Ayele et al. (2020), for instance, are important for the post assessment, as they demonstrated the need to continue examining mental health service utilization and access among African immigrants in the United States. The findings also indicated that there are various barriers and facilitators for service, but previous research has focused largely on a quantitative approach. Escamilla and Saasa (2020) suggested that there is a further need to understand African immigrants in the United States and both the external and internal factors that impact these mental health variables. McCann et al. (2018) suggested a need for renewed research regarding how to best meet the needs of sub-Saharan African migrants. Therefore, I sought to fill this meaningful gap in the literature concerning the experiences of sub-Saharan African immigrants in the United States in accessing mental health services.

Purpose of the Study

The purpose of this qualitative study was to explore the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore. The phenomena of interest were mental health service access, mental health service utilization, and mental health barriers. The target population for this study comprised sub-Saharan African immigrants. For this general qualitative inquiry, I used semistructured interviews. The semistructured interviews were appropriate for this study as they provide a framework for gathering rich exploratory data based on the experiences of the

participants. The qualitative data were analyzed using Braun and Clarke's (2006) six-step thematic analysis.

Research Question

This qualitative study was guided by one central research question that allowed me to address the purpose of the study, which was to explore the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore. The research question was as follows: What are the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore?

Conceptual Framework for the Study

The theoretical framework that was used for this study is Andersen's behavioral model of health service use. This model is an expansion of Andersen's (1995) behavioral model of health service utilization (Graham et al., 2017). The original model focused on exploring how and why persons utilize healthcare services, examining inequality in access to medical services, and assisting in the formation of laws which will facilitate equitable access to healthcare (Travers et al., 2020). To explain or predict a person's utilization of healthcare services, the original framework of Andersen's behavioral model precisely focused on the person's predisposition to utilize acute medical care services, facilitating factors that enable utilization, as well as one's influenced or perceived need for care (Isaak et al., 2020). Andersen's behavioral model allowed me to examine measures of health care access, such as efficiency, effectiveness, and equity, as well as comprehend the environment affecting access and use of healthcare services.

The behavioral model aims to examine the use of healthcare services, facilities, and barriers to the use of medical services (Giano et al., 2020). The model provides an assessment regarding the external and internal factors that may impact the use and access to healthcare services (Bauldry & Szaflarski, 2019). The Andersen behavioral model has been used significantly in examining migrant and immigrant access and service usage for mental and physical health purposes (Bauldry & Szaflarski, 2019; Giano et al., 2020). In terms of this study, I used Andersen's behavioral model of health service use as a means of exploring internal and external factors as described by the participants within this study in terms of subsidy errand mail immigrant access to mental health services in Baltimore. The logical connections between Andersen's behavioral model and the nature of my study (general qualitative assessment) include a guideline for the systematic identification of factors that influence individual decisions to use or not use available healthcare services.

Nature of the Study

To address the research question in this qualitative study, the specific research design included a general qualitative inquiry. I chose the qualitative method as it is ideal for the exploration of a phenomenon that requires the subjective opinions, perceptions, and experiences of participants (Merriam, 2002). A qualitative approach is ideal for the exploration of a phenomenon through statistical data to address a measurable or testable phenomenon and to assess the relationships among variables. Researchers who employ a quantitative approach address a testable phenomenon that can be addressed with a hypothesis and descriptive or inferential statistics (Alexander, 2021).

For this study, a quantitative methodology would not have been ideal, as my aim was not to measure a phenomenon or collect data that were testable. Instead, the qualitative methodology facilitated an exploratory approach, enabling me to collect rich data regarding the topic of this project from participants' perspectives. The qualitative approach was ideal for gathering data through interviews that provided insights that directly addressed the research questions.

The generic research design was considered and chosen for this study. The generic research design is used for describing and discussing a phenomenon from the perceptions of participants (Kostere & Kostere, 2021). With this design, data can be gathered through interviews, surveys, or other methods that directly gain the participants' reflections (Merriam, 2002).

The target population for this study included sub-Saharan African immigrants. The purposeful sampling approach was employed to recruit eight to 12 sub-Saharan African immigrants in Baltimore who had experienced mental health conditions and barriers and had sought relevant healthcare services. I used purposeful sampling to obtain participants because this approach allows the researcher to utilize his or her judgment when selecting members of the population as participants in a study (Ghaljaie et al., 2017). This approach enabled me to select only sub-Saharan African immigrants in Baltimore who had experienced mental health conditions and barriers and had sought relevant healthcare services.

For this research design, general qualitative assessment, I utilized semistructured interviews to gather data. The semistructured interviews were appropriate for this study

as they provided a framework for gathering rich exploratory data based on the experiences of the participants. Semistructured interviews allow for a guiding question that is accompanied by probing questions based on the responses of the participants (Mahat-Shamir et al., 2021). The use of the semistructured interview guide greatly aided me in gathering the perceptions of participants to answer the research questions. For this purpose, I employed a semistructured interview guide, which was assessed by an expert panel. The use of a semistructured interview guide ensured that the questions provided to participants aligned with the research question and the purpose of this study.

Definitions

Andersen's behavioral model: This model is used to examine the use of healthcare services, facilities, and barriers to the use of medical services (Giano et al., 2020).

Immigrants: Immigrants are people living in a nation different from the one in which they were born (Anderson & Connor, 2018).

Mental health: Mental health refers to our social, psychological, and emotional well-being (Arango et al., 2018).

Mental health services: These are interventions in the form of counseling, assessment, diagnosis, or treatment provided in public, private, outpatient, or inpatient environments for the improvement or maintenance of mental wellbeing or the treatment of behavioral or mental illnesses in individual and group settings (Arango et al., 2018).

Mental illnesses: Mental illnesses refer to health conditions involving behavior, thinking, emotion, or a combination of these three aspects (Arango et al., 2018).

Sub-Saharan Africa: Sub-Saharan Africa is, geographically, the region of the African continent that lies south of the Sahara (Wang & Dong, 2019).

Sub-Saharan African immigrants: Sub-Saharan African immigrants are persons who migrated willingly from their native sub-Saharan African region to reside permanently in the United States (Anderson & Connor, 2018).

Assumptions

Assumptions in research are aspects that are accepted as true, or at least sensible, by scholars and peers who will read a research work (Brown, 2019). Although assumed, these aspects should be explicitly stated in the body of research work (Brown, 2019). For this study, I, as the researcher, was the main research instrument for gathering, transcribing, and appraising data. For data collection, I targeted sub-Saharan African immigrants in Baltimore who have experienced mental health conditions and barriers and have sought relevant healthcare services. I assumed that the selected respondents would truthfully share their experiences and barriers while accessing mental health services. Truthful data facilitated the generation of rich descriptions concerning the respondents' pertinent experiences.

The second assumption was that the semistructured interviews with a chosen sample of between eight and 12 (see Chapter 3 for more details on sample size) sub-Saharan African immigrants in Baltimore were sufficient to acquire saturation and that findings may be transferrable to other settings and instances regarding mental health support among sub-Saharan African immigrants in the United States. As the researcher, I played a role in determining the adequacy of the interviews, particularly by reducing bias.

Specifically, I tried to reduce the impact of bias by employing suitable steps to guarantee the trustworthiness of data as well as by ensuring confirmability, dependability, transferability, and credibility.

Scope and Delimitations

Scope and delimitations are controllable aspects of a study. The scope outlines how comprehensive a study is to explore the research questions as well as the parameters in which the study will operate relative to the timeframe and population (Theofanidis & Fountouki, 2018). The objective of this qualitative study was to explore the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore. The phenomena of interest were mental health service access, mental health service utilization, and mental health barriers. The target population for this study comprised sub-Saharan African immigrants in Baltimore who had experienced mental health conditions and barriers and had sought relevant healthcare services.

The delimitations, on the other hand, are the variables and factors not to be comprised in a study (Theofanidis & Fountouki, 2018). In this study, the respondents were limited to sub-Saharan African immigrants in Baltimore who have experienced mental health conditions and barriers and have sought relevant healthcare services. Thus, individuals who did not meet these criteria were not included in the study.

Limitations

Limitations refer to the aspects of a study that the researcher cannot control, and which provide context for the findings. These are influences, conditions, or shortcomings that place restrictions on the selected methodology and conclusions (Theofanidis &

Fountouki, 2018). The anticipated limitations in this study were linked to the chosen research design, general qualitative assessment. The limitations of this approach are, first, researcher bias. Researcher bias is the possibility that the researcher's perceptions or opinions will impact the findings of this study (Merriam, 2002). To avoid researcher bias, I used reflexive journaling, which is the process of documenting bias throughout the data collection analysis process.

The second limitation was the truthfulness of the participants. It is not possible to verify that participants are truthful, but I made every effort to ensure that the participants were comfortable during the semistructured interviews. The last limitation was the sample size and the possibility of transferability. The small sample size of a generic qualitative study limits the transferability of the findings. However, I extended the possible implications of the findings by discussing the thematic results through a review of congruent literature, recommendations for practice, and recommendations for research.

Another limitation is that the study was limited to sub-Saharan African immigrants in Baltimore who had experienced mental health conditions and barriers and had sought relevant healthcare services. The quality of this study was dependent on the access to a sufficient sample of sub-Saharan African immigrants who met these criteria for inclusion and could deliver comprehensive experiences with mental health utilization and barriers. To address this limitation, I adopted the purposeful sampling method. Purposeful sampling was effective in achieving an adequate and relevant sample because this sampling tactic allows the investigator to rely on their judgment when selecting

members of the population as participants of a study (see Chapter 3; Ghaljaie et al., 2017). Using a purposeful sampling method may facilitate saturation.

To improve dependability, I consulted methodology and content specialists to assess the research questions and semistructured interviews. I further asked respondents to review a summary of their transcripts as a way of verifying the accuracy of their transcribed responses, which is a process known as member checking. I also recorded reflections and comments in all segments of data gathering and analysis as part of the audit trail procedure.

To improve the possibility of transferability, I provided explanations of processes for data collection, analysis, and interpretation. I described the research methodology, design, and settings so that respondents' completed data could be transferable to other groups of sub-Saharan African immigrants and contexts. Lastly, I improved the possibility of transferability by the use of rich, in-depth descriptions for creating credibility in the qualitative study.

Significance

This study has both empirical and practical significance. The study may contribute to research and scholarship by extending the current findings regarding sub-Saharan African immigrants' use and access to mental health services. This study may provide new information that can benefit researchers and demonstrate new topics that can ultimately benefit the access to and use of mental health services among sub-Saharan Africans in the United States. The current study is significant for practice because it provides new information regarding sub-Saharan Africans' perceptions of access to

mental health services in Baltimore. Practitioners in Baltimore may find that these perceptions aid in an assessment of how to improve access to and use of mental health services among this population. These findings may also improve policy and practice contributions by demonstrating the opportunities for change in mental health immigrant access and use. The findings may also benefit positive social change by improving mental health outcomes and service utilization among sub-Saharan African immigrant populations.

Summary

The research problem that was addressed by this study was the lack of mental health service utilization and barriers to mental health care among the sub-Saharan African immigrant population (Ayele et al., 2020; Escamilla & Saasa, 2020; Saasa et al., 2021a, 2021b). The rationale for conducting this study was to assess the unique experiences of sub-Saharan African immigrants in the United States, as their numbers are increasing rapidly. Out of the 40 million immigrants in the United States, slightly more than 2 million are from sub-Saharan Africa (Fazel-Zarandi et al., 2018). While this population remains small, representing only 4.5% of the country's 40 million immigrants, it is a rapidly growing population. The mental health concerns of sub-Saharan African immigrants, therefore, have implications for the overall health of the U.S. population. Social implications for understanding the cultural principles for sub-Saharan African immigrants entail how to better comprehend their mental health service utilization and barriers. The current study was important for practice by providing new information concerning sub-Saharan African males' perception of access to mental health services in

Baltimore. Practitioners in Baltimore may find that these perceptions aid in an assessment of how to improve access and use among this population.

I adopted a qualitative research methodology and general qualitative assessment research design. The target population for this study encompassed sub-Saharan African immigrants. The purposeful sampling approach was employed to recruit between eight and 12 sub-Saharan African immigrants in Baltimore who had experienced mental health conditions and barriers and had sought relevant healthcare services. For the research design, I utilized semistructured interviews for data collection. The semistructured interviews were appropriate for this study as they provide a framework for gathering rich exploratory data based on the experiences of the participants.

In Chapter 2, I review the scholarly literature related to these topic areas. In Chapter 3, I discuss the research design, data collection methods, sampling, and data analysis. The gathered qualitative data were analyzed using Braun and Clarke's (2006) six-step thematic analysis. NVivo 12 Pro software was employed for the organization and management of qualitative data. The software further facilitated the organization of transcribed data into themes and subthemes, which are interpreted and presented in Chapter 4. In the following chapter, I present the literature review based on the identified research question and phenomena.

Chapter 2: Literature Review

Sub-Saharan African immigrants are a fast-growing subsection of immigrants in the United States. Currently, they represent about 2 million of the 40 million immigrants currently residing in the United States (Fazel-Zarandi et al., 2018). Though a small percentage overall, immigration from the region is increasing, and sub-Saharan Africans constitute a larger and larger portion of the immigrant population. Given this growth, it is of increasing concern to understand the sub-Saharan African experience vis-à-vis the country at large. The purpose of this qualitative study was to explore the experiences of sub-Saharan African immigrants with accessing mental health services in Baltimore.

Immigrant populations face diverse challenges after arrival in their host nation. Lack of language skills and acculturation are primary and significant initial hurdles new arrivals must navigate in order to acculturate and adequately access services and institutions (Ahad et al., 2019). Immigrants also sacrifice significant social capital in their transition to a new nation, leaving behind personal networks and extended families in their country of origin (Kamrul et al., 2021; Tegegne, 2018). Other factors such as discrimination and low socioeconomic status also contribute to high levels of psychological stress on the incoming population (Agbemenu et al., 2018; Pachter et al., 2018). These stressors often manifest as more serious mental health issues causing both psychological and physical symptoms. There are a variety of healthcare programs that cater to both the general population and immigrants specifically, but divergent levels of healthcare utilization among varying ethnic groups remains a barrier for equitable health outcomes.

This study explored sub-Saharan African immigrants' experiences with the mental healthcare system in Baltimore. Using Andersen's (1995) model of healthcare utilization, I investigated the barriers to effective treatment among this population and garnered insight into the factors that enable or prevent care. Identifying the barriers to healthcare utilization among this specific subset of immigrants remains a critical avenue of research in public health outcomes. Understanding these barriers will help policymakers and healthcare professionals with outreach and increasing utilization. This study posed a single research question: What are the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore?

Literature Search Strategy

The literature reviewed in this chapter was collected from a variety of online databases. Google Scholar and JSTOR were the primary search nodes, with some sources coming from EBSCO and PubMed. I began the search by investigating the theoretical framework (Andersen, 1995) and then moved to literature review sources. Finally, I examined empirical studies. Keyword searches included combinations of *mental health*, *immigration*, *Andersen behavior model*, *sub-Saharan African*, *(barriers to) healthcare utilization*, *literacy*, *acculturation*, and *stigma*. These keywords were used to identify relevant literature, which was subsequently included in this literature review.

The majority of the literature used in this chapter was published between 2018 and the present, with 60 of the 70 sources falling in this time frame (85.3%). I included some literature published before this period when discussing the theoretical framework. With limited research published under the specific parameters of sub-Saharan African

immigrant mental health, the scope of the literature review was expanded to incorporate more general frames of healthcare and include insights from a diversity of immigrant communities.

The chapter is organized in the following manner. First, I discuss the theoretical framing, Andersen's (1995) model for healthcare utilization. Next, I present a review of the literature as it pertains to Andersen's model, covering predisposing characteristics, enabling factors and barriers, need, and utilization. Next follows a short discussion of the adaptations to multicultural healthcare challenges followed thereafter by the conclusion.

Theoretical Framework

In this dissertation, I used Andersen's (1995) behavioral model to predict and explain mental healthcare utilization among sub-Saharan African immigrants. Andersen's model was originally developed to explain diverging patterns of healthcare utilization among different ethnic and socioeconomic populations. The model frames the interaction between environmental and individual characteristics on the decision calculus of whether or not to seek mental health treatment.

Andersen's (1995) model establishes the external environment and healthcare system in which treatment will take place (Giano et al., 2020). On the macro scale are environmental conditions. The healthcare institutional framework, costs and quality of care, and prevalence of adequately trained professionals create an ambient set of possible treatments for the general population. It is within this broader healthcare system that the population characteristics rest and interact with the general environment (Andersen, 1995; Giano et al., 2020).

The next component in explaining healthcare utilization is the predisposition characteristics that act on the individual. The social structure of the community, presence of role models, and general conceptualizations of health within different subcultures all influence the perception of and interaction with the healthcare system. A given community may encourage different approaches to health, whether Western medicine or traditional native therapies. Health beliefs can be formative in healthcare decisions and reflect values, conceptualizations, and social contexts (Isaak et al., 2020)

Predispositions stem from a variety of sources. Immutable characteristics, such as demographics, matter. The age and gender of an individual may play a significant role in the individual's need for interventions. Furthermore, age-related conceptions of vulnerability may make elderly individuals more likely to seek professional help in the event of illness or discomfort (Hulka & Wheat, 1985). Other characteristics such as education, occupation, and income affect one's peer groups and preconceived notions on treatment. Values, beliefs, and understandings of mental health affect an individual's desire for treatment but do not totally predict utilizing the healthcare system (Isaak et al., 2020).

Predisposing characteristics interact with enabling factors. Enabling factors provide the individual with the means to pursue treatment should they deem themselves in need. These factors may be formal resources, such as health insurance or money, as well as information resources that inform the individual about care options. Alternatively, informal resources may include social support of the patient, adequate time, or motivation to attend treatment (Andersen, 1995).

Finally, the most salient factor in Andersen's model is need, both perceived and evaluated. Individuals without the need for mental health treatment will generally not pursue it. Perceived need corresponds to a person's self-evaluation of their mental health needs. This self-perception stems from both physical and psychological wellbeing (or lack thereof) interacting with the aforementioned personal characteristics. Evaluated need comes from outside actors evaluating and diagnosing the individual, whether a member of the community, family, or a mental health professional.

There have been several contributions and iterations of the model as it has evolved over the decades. This has included a robust debate on how the constituent parts influence each other, and whether new categories should be added. Hulka and Wheat (1985) argued for the addition of age and gender as predisposition characteristics that help predict healthcare, given that the likelihood of care increases with age, and the type of care needed may be influenced by gender. Another contribution came from Bass and Noelecker (1987), who criticized the model for not paying adequate attention to social networks as facilitating features of utilization. Becker and Louis (1983) introduced the importance of health beliefs of individuals, arguing that one's beliefs about treatment and best practices will influence decisions. Travers et al. (2020) examined elderly care through the model, arguing that end-of-life care is categorically different than acute treatments. Although it has not been added to the model, True et al. (1997) argued that genetic components are highly relevant to the prediction of medical care utilization, as genetic features may predispose individuals to certain types of diseases. Another debate revolves around the interaction between elements. Although there is consensus on the

salience of the major factors (i.e., predisposition characteristics, barriers, need), there is debate around the relationship between them (Graham et al., 2017). This study utilized Andersen's updated 1995 model, which includes these new additions as well as the inclusion of feedback loops.

The most recent iteration of the model includes feedback loops between care received and the perceived efficacy of treatment. If an individual deems the healthcare intervention to be satisfactory, then they are far more likely to return for repeated care. However, if an intervention is perceived to be ineffectual or even harmful, it creates a barrier to repeated treatment, both with the same provider or alternative methods (Andersen, 1995).

Andersen's (1995) theory has been widely utilized since its conception to frame and understand healthcare utilization among a wide variety of ethnic, socioeconomic, and demographic groups. Its longevity in the field attests to its utility in understanding healthcare utilization (Bauldry & Szaflarski, 2019; Giano et al., 2020). Although there have been attempts to build other models around mental health utilization (Arora et al., 2020), Andersen's model remains the most widely used. For these reasons, it was a useful tool for examining the research question at hand.

Review of Key Concepts

Population Characteristics: Predisposition Factors

Andersen's (1995) model postulates that individuals are predisposed to certain interactions with the healthcare system beyond their personal choices. In this section, I review the literature on these predisposition characteristics and their observed influences.

The first of these characteristics is demography. Ethnicity, age, and gender have all been observed to significantly influence not only the degree of health service engagement, but also the manner.

Ethnicity

Ethnicity is a critical component for two principal reasons. First, ethnicity tracks closely with race, which is a strong indicator of discrimination. Discrimination has deleterious effects on mental health and is a demotivating factor for healthcare utilization. (Ahad et al., 2019; Evans & Sheu, 2019; Ichou & Rivenbark, 2020; Pérez-Urdiales et al., 2019). Second, ethnicity carries with it deep cultural and social undertones that may influence perceptions of physical and, especially, mental health (Aneshensel et al., 2018; Jen'nan & Paige, 2018). These cultural dynamics are discussed later in this literature review.

Age plays a significant role in one's physical health. Age tends to be negatively correlated with physical ailments and, thus, health care underutilization tends to be expressed most by young men (Evans & Sheu, 2019; Islam et al., 2017). In immigrant communities, age plays a significant role in mental health as well. Youths tend to spend more time online, and research by Tynes et al. (2019) demonstrated that discrimination and racism experienced online can have deleterious mental health effects. Youths who were born outside the country have left behind their home and experienced often harrowing experiences when arriving in a new country (Enos, 2019). While a product of their home nations, they also inherit their parents' culture, which may be disadvantageous when attempting to integrate (Alaazi et al., 2018; Tulli et al., 2020). Furthermore, they

are more susceptible to traumas incurred early in life (Jensen et al., 2019). They are also more susceptible to peer pressure, stigma, and ostracization (McCann et al., 2018). It should be noted that these stressors do not always lead to mental health conditions worse than in the general population. Filion et al. (2018) examined rates of depression among noncitizen adolescents and found that they were lower than the recorded rates among native-born children. This could be due to higher rates of resilience among the noncitizen population, high ambient rates of mental health issues among native-born adolescents, or problems with accurately measuring mental health. As this study was conducted through a large macro survey, more in-depth qualitative investigation on the subject is warranted.

Young immigrants have advantages in terms of acculturation and language acquisition, both of which aid in lowering anxiety. Through school and sports, they tend to be better integrated into public institutions than their parents and gain greater insight into the national culture (Alaazi et al., 2018). Multigenerational studies have demonstrated a significant decrease in anxiety and stress among subsequent generations of immigrants (Lee, 2019).

Gender

Gender predisposes individuals through two avenues. First, certain psychological and health conditions have been shown to affect men and women differently and thus elicit different reactions and treatments, such as in the case of human papillomavirus (Ko et al., 2019). For medical conditions that affect women more than men, one can reasonably expect these patterns to emerge. Second, gender norms may shape different conceptualizations of duty and health (Adegboyega et al., 2019). Shafeek and Driver

(2020) examined gendered differences across varying ethnicities and found strong trends of gendered patterns of healthcare, but only in certain ethnic groups, suggesting that much of the divergence is cultural in nature. Escamilla and Saasa (2020) found that African immigrant men and women displayed similar psychological stressors, such as loneliness and discrimination, yet diverging responses in other areas. Women saw much larger increases in anxiety and stress based on marital status and income. Olukotun et al. (2019) recorded the unique experiences and stressors of immigrant women living as undocumented workers. Ichou and Rivenbark (2020) described how African immigrant women in France perceived higher degrees of discrimination and displayed more avoidant behavior to the health system. These gendered differences, while sometimes physiological, are often dictated by culture.

Intersectionality, Culture, and Culture Shock

Ethnicity, age, and gender combine to predispose an individual to needing to utilize healthcare services. Though they are not primary determining factors, these predispositions shift macrotrends in healthcare utilization. They also interact with Andersen's next population-level category. Demographic factors are further complicated by cultural variables. Cultures adopt different approaches to physical and mental health prevention and treatment. Among immigrant groups, cultural alienation is a common feature. This remains an understudied dimension in the immigrant experience. Cultures are not plucked and transported wholesale from their nation of origin; the experience of immigration is itself an endogenous cultural experience that has repercussions on mental health and outlook (Alegría et al., 2017; Woodgate & Busolo, 2018).

Culture shock and a reorientation of expectations is a common experience for new arrivals. Okeke-Ihejirika and Salami (2018) examined African immigrants' response to this acculturation process. Many African men struggled with the transition and reconstitution of their masculine identities. These constituted a significant psychological burden as they attempted to conceptualize their own understanding of masculinity, not just for themselves, but as a father and husband. Chao et al. (2020) investigated rates of mental health utilization in New York City immigrants. The data demonstrated a diminishing resistance to care that correlated with age. Older immigrants and those newly arrived were less likely to view mental health treatment positively than younger immigrants.

Sub-Saharan African immigrants display some unique features on the cultural front that have implications for mental health. Kpanake (2018) explored some of the sources of cultural understanding of personhood and mental health for sub-Saharan African immigrants. While Kpanake admitted that there is no unifying single African culture, there are significant similarities between communities. Kpanake described the concept of *ubuntu* central to the cultural conception of the person in the community, as the individual exists only in relation to the wider community and spiritual realm. Mental health issues are believed to stem from a misalignment of social relationships, thus representing an issue for the wider community. Mental health treatment is a matter of community concern. However, malignant supernatural or spiritual forces are also believed to cause mental health issues, and those exhibiting symptoms are to be treated with caution (Kpanake, 2018). This communal orientation is expressed in a revealed

preference among African immigrants for community, rather than clinical, treatments for mental health issues.

Spirituality

Another unique cultural feature of sub-Saharan African conceptions of mental health is the role of malevolent spirits. In addition to the centrality of community in understanding personhood, spirituality and connection to the spiritual realm are equally important (Kpanake, 2018). However, this spiritual dimension is vulnerable to malevolent forces that may curse, infect, or otherwise disrupt spiritual wellbeing. McCann et al. (2018) documented the significant pressure sub-Saharan African immigrants felt to hide symptoms of psychological wellbeing in order to avoid stigma associated with potential supernatural causes of mental health. Furthermore, this stigma was persistent in the children of immigrants, demonstrating the potential for reproduction of cultural beliefs.

Barriers to Healthcare Among Immigrants

Predisposing factors interact with factors that facilitate or bar individuals from accessing care. These resources may include access to financial resources. They can also be informational or cultural and similarly facilitate access to healthcare. Alternatively, the lack of resources, whether financial, informational, or cultural, can just as easily erect barriers to access (Andersen, 1995). In this section, I review the literature on the barriers that immigrants face.

Financial

Financial barriers to healthcare are perhaps the most obvious and well documented hurdles in accessing treatment (Brow et al., 2020; Hendrie et al., 2020). Immigrant populations are often at the low end of the socioeconomic spectrum and struggle to meet the financial obligations of everyday life. Luo and Escalante (2018) investigated the rates of health care utilization among immigrant populations in the American Southwest and found that the sampled population underutilized healthcare services. Among the stated reasons for avoiding care was prohibitive cost.

Financial barriers were particularly high among African immigrants who, despite being more educated than the average immigrant, often do not have adequate financial resources (Amako & MacEachen, 2021; Tulli et al., 2020). Adekeye et al. (2018) found that concerns around cost dissuaded nearly half of the surveyed African immigrants to access care. In addition to low incomes, immigrants tend to be under-insured, thus imposing further financial costs of care. This is due to several factors. First, immigrants are often employed in temporary or irregular work, paid under the table, or are in a field that does not offer health care benefits, depriving them of access (Ahad et al., 2019; Amuedo-Dorantes & Antman, 2017). Second, immigrants who are in the country illegally fear reprisal if they are caught using public healthcare, leading them to avoid contact with healthcare services whenever possible (Luo & Escalante, 2018). Second, immigrants struggle to navigate the complicated bureaucratic healthcare institutions with limited financial or linguistic resources at their disposal (Endale et al., 2020).

Insurance

This segues into another principal resource needed to facilitate healthcare utilization. Just as one needs information and know-how to navigate the insurance system, one needs information on a wide variety of healthcare institutions, rules, and practices in order to properly utilize services. Immigrant populations often do not have these skills or information and, thus, remain ostracized from the healthcare system (Boettcher et al., 2021; Boukpessi et al., 2021; Brow et al., 2020; Davis et al., 2017). Without regular contact with healthcare professionals, individuals may not receive necessary and regular checkups, which are critical in identifying illness before it becomes severe (Chao et al., 2019).

Medical history is a key blind spot for many immigrants who come from underdeveloped nations. It may be difficult or impossible to access the medical histories of those who come from regions without robust healthcare systems or who flee unstable regions. Immunizations, allergies, and family records are unknown and, therefore, cannot be incorporated into medical assessments. This also means that refugees and immigrants may go untreated for physical and psychological ailments that go untreated and undiagnosed (Rosenthal, 2018).

The ability to navigate the complicated space of insurance and public hospitals was a barrier to service among some groups. Those who did not feel comfortable with hospitals opted for free clinics tailored to local immigrant populations rather than normal services (Adekeye et al., 2018). This research suggests that outreach to underserviced

communities is effective at treating populations that may not otherwise access the healthcare system.

Acculturation

Acculturation is key in making sure information is accessible to different groups. Asian immigrants in New York city who were less acculturated, measured by language and time in the country, were more likely to avoid Western hospitals and utilize traditional Eastern medicines (Akresh, 2009). While homeopathic treatments generally are not deleterious to health, if they are pursued in exclusion of Western medicine, health outcomes will deteriorate. In more severe cases, cultural isolation leads to being totally unaware of viable treatment options, rather than just being mistrustful. Lack of acculturation creates blind spots for some individuals (Kamrul et al., 2021).

On the other hand, high rates of acculturation in New York City led to higher rates of healthcare utilization (Brow et al., 2020; Chao et al., 2019). High levels of acculturation also led to higher expectations in quality of care. As a result, immigrants were more likely to pursue treatments. This high level of trust among acculturated individuals encourages repeated interactions with the system (Davis et al., 2017; Luo & Escalante, 2018).

Developing knowledge about a given country's healthcare system takes time. Costs, insurance, protocols, and regulations differ by country, and immigrants must adapt to a new institutional environment. Khuu et al. (2018) found that Hmong immigrants developed more robust understandings of the mental health services over time spent in the country, and this understanding was positively linked to greater healthcare utilization

– that is, the more time spent in the country, the more they were able to navigate the system. This correlation indicates that acculturation plays some role in increased health literacy.

There is also a belief among many groups that mental health treatments, while they may be effective for the native, Western population, are ill-suited for immigrant psychologies (Pérez-Urdiales et al., 2019). This belief that Western methods of healthcare, especially mental healthcare, are unsuited to specific cultural particulars has a dampening effect on treatment. Ko et al. (2019) demonstrated the efficacy of information dispersal, especially when provided by a culturally literate or co-ethnic individual. Cultural barriers to care may be overcome if information is dispersed by the right messenger. Inadequate health outreach could isolate and ostracize certain underserved populations. Zhou et al. (2019) found divergent rates of health literacy among different ethnic groups, specifically Hispanic and Asian and Pacific Islander immigrants. The source of this lack of information is unconfirmed but may be due to culture or lack of adequate outreach.

Information access and acculturation is not easy to measure. These studies predominately rely on self-reporting or proxies, such as language skill, as a measure of integration (Akresh, 2009). Some researchers have attempted to fill this gap in the research. For example, Oppedal et al. (2020) developed a framework for understanding youth integration and acculturation. Furthermore, research indicates that different cultures may respond to these barriers in different ways. Whether or not an individual

overcomes these barriers and utilizes the resources at their disposal is often a matter of Andersen's (1995) third component of population characteristics: that of need.

The Mental Health Issues, Themselves

Finally, a significant barrier is the stigma associated with mental health issues among many immigrant communities. Stigma against seeking mental health treatment is a common reason for individuals to not seek mental health care, regardless of ethnicity, race, or immigration status (Graham et al., 2017). However, stigma is more pronounced among immigrant populations, especially when compared to nonimmigrant populations. Boukpessi et al. (2021) found that 18% of African immigrants would "never consult" a mental health professional, compared to just 1% of the general population. Some data suggest that this is a common characteristic among both African immigrants and African Americans, though the reasons for this may be different (Brow et al., 2020; Evans & Sheu, 2019; Hendrie et al., 2020). Some scholars argue the unique conceptualization of mental illness as a social and supernatural illness that increases the perceived stigma among the community (Kpanake, 2018; McCann et al., 2018; Tulli et al., 2020). One fear related to stigma is the possibility that one's mental health status will become public knowledge. Fear of "airing one's dirty laundry" and concerns about confidentiality were consistent among those who were resistant to consulting a mental health professional (Brow et al., 2020; Hendrie et al., 2020; Kamrul et al., 2021; McCann et al., 2018).

Paradoxically, there is a persistent trend in the literature of immigrant communities in general, and African immigrant communities, specifically, in seeking community help for mental issues. These results were supported by evidence from

Australia, where McCann et al. (2018) interviewed 28 African immigrant youths and their parents (N = 41) about mental healthcare utilization and stigma. The results showed strong cultural stigma around seeking help, stemming from a fear of ostracization from the community. Participants expressed concerns about being labeled a "lunatic." The main findings were that public stigma suppresses mental health therapies and reinforces self-imposed stigmas on individuals. This stigma is based in deeply rooted cultural beliefs about mental health and that mental health issues stem from supernatural causes, such as witchcraft. This belief further reinforces stigma.

Need for care is the final component of Andersen's (1995) model that demands attention. Even if an individual is armed with all the most accommodating personal predispositions, granted all the necessary resources, and avoids all the barriers, if there is no perceived need for care, an individual will likely not seek it. It is important to note that there is a categorical distinction made in Andersen's (1995) framework.

Andersen distinguishes between perceived need and evaluates need. A perceived need is the subjective self-evaluation of the patient who decides whether or not they are in need of care (Andersen, 1995). Evaluated need is often undertaken by a healthcare professional and is usually diagnostic in nature. One should note that need is often the final and most powerful of the pre-utilization forces. Severe need will likely supersede barriers of predisposition and resource. In short, need is often the most salient factor in seeking mental health treatment (Graham et al., 2017).

The need for mental health services comes from a variety of sources. Experiences of trauma, chronic and acute sources of stress, or even genetic predispositions may be

triggers for a mental health episode. Immigrants are at heightened risk of mental health stressors that affect the general population (Agbemenu et al., 2018; Brow et al., 2020; Kamrul et al., 2021). In the following section, I discuss literature related to immigrants' access to and use of healthcare services.

Immigrants Access and Use of Healthcare Services

The phenomenon of depressed immigrant interaction with the healthcare system is not limited to the United States, and global research into patterns of underutilization of healthcare services by immigrants has abounded. Research has even been conducted in nations that are not common destinations for immigration. For example, China has seen a recent influx of workers, immigrants, and exchange students from Africa, and researchers have yielded data on persistent exclusion from the healthcare system (Xiong et al., 2021). It should be noted, however, that African immigrants are not the individuals who experience exclusion. Chinese nationals who do not hold local residence permits called *Hukou* in Beijing also use public health services less often than Beijing residents (Jin et al., 2018). This research in China suggests that immigration status affects healthcare utilization beyond cultural or linguistic exclusion.

European nations have seen an influx of immigration from the Middle East and North Africa, triggering research into the recent settlers. In Germany, Klein and Knesebeck (2018) observed lower rates of healthcare utilization among immigrant populations, predominately those of Turkish origin. French immigrants also experienced lower healthcare utilization rates due to perceived discrimination in the healthcare system

(Ichou & Rivenbark, 2020). In Spain, African women were found to have similarly depressed levels of utilization (Pérez-Urdiales et al., 2019).

Canada is a closer and perhaps more appropriate nation of comparison for the United States. Geographically proximate, ethnically diverse, and relatively open to immigration, Canada shares both linguistic and institutional similarities with the United States and has produced a preponderance of research on its immigrant communities' interaction with its healthcare services (Amoako & MacEachen, 2021; Anderson et al., 2017; Bamvita et al., 2018; Kamrul et al., 2021). These studies, along with many others in this review and elsewhere, demonstrate a consistent underutilization of healthcare services in their host nations. Andersen's (1995) framework utilizes both predictive and explanatory factors for the purposes of explaining healthcare utilization.

Given the difficulties immigrants face in healthcare treatment, researchers have investigated ways to more effectively treat immigrant and ethnic minority populations. Improved effectiveness of multicultural patient care is a persistent goal in the healthcare community. Handtke et al. (2019) reviewed proposals of multicultural care in hospitals and clinics. Commonly cited improvements involved patient outreach, better linguistic and cultural matching, and better training for healthcare providers.

Patient outreach is a significant challenge for hospitals and mental health professionals. Given the high-risk profile and potential barriers to treatment, there has been a keen interest in identifying interventions in the healthcare system that can facilitate treatment. Literature reviews conducted by Handtke et al. (2019) and Hendrie et al. (2020) chronicle the most common prescriptions for healthcare providers. Chief

among the prescriptions is more effective patient outreach. As noted, immigrant and minority communities are often alienated from the healthcare system by a variety of barriers. Increased information and patient outreach may increase utilization among these populations. Another prescription is improved language resources. First generation immigrants are at increased danger of alienation, lack of acculturation, and lack of language skills (Hendrie et al., 2020). Providing resources, especially written resources, in a variety of languages may increase patient engagement with professionals.

Another set of prescriptions involves retraining at the individual and organization level (Hendrie et al., 2020). Research has indicated that mental health professionals are often undertrained in relation to race-based traumas. Healthcare providers reported feeling unqualified and uncomfortable when addressing these types of stressors. Furthermore, Hemmings and Evans (2018) indicated that there is inadequate cross-cultural training to treat mental illness. These observations require retraining programs at the individual level in order to better equip healthcare professionals to better serve a diverse population. Olcoń and Gulbas (2018) examined the healthcare experiences of youths and echoed these findings, arguing for a more culturally competent approach to care.

For the children of immigrants, schools can provide a meaningful intermediary between the state and the family. While parents may be hesitant to access mental health services, schools have direct contact with children. Thus, school outreach is another possible avenue for increased utilization (Tulli et al., 2020).

Significant Stressors Among the Immigrant Population

Discrimination is a persistent stressor in the lives of immigrants that can exert psychological pressure on those who suffer from it. Research has repeatedly and decisively chronicled the impact of discrimination on immigrant mental and physical wellbeing (Agbemenu et al., 2018; Ahad et al., 2019; Amoako & MacEachen, 2021; Bauldry & Szaflarski, 2019; Evans & Sheu, 2019; Saasa et al., 2021). Immigrants are at heightened risk for discrimination due to the intersectional identities as ethnic minorities and immigrants. Pampati et al. (2018) compared rates of discrimination between native-born Arab Americans and recently arrived Arab immigrants. The immigrant population showed increased risk of discrimination and other pathologies, such as depression and anxiety. Ahad et al. (2019) investigated the diverging experiences of African Americans and African immigrants in Utah. After comparing the health care outcomes of the two groups, the authors found that the immigrant population sought lower rates of health care assistance, in part due to perceived discrimination. Discrimination can yield downstream stressors as well, as it often has deleterious effects on income (Bauldry & Szaflarski, 2019).

Socioeconomic Status

Immigrants are more likely to suffer from low socioeconomic status for several reasons. Discrimination, as mentioned above, may suppress wages and employment opportunities (Bauldry & Szaflarski, 2019). Recent waves of race and diversity-based anxieties have been connected to increased discrimination among majority ethnicities (Kirmayer, 2019). New arrivals in the host country likely have less social capital and

have fewer networking opportunities, which have been shown to correlate negatively with treatment and health outcomes (Tegegne, 2018). Education is another limiting factor that keeps immigrant communities in poverty. African immigrants in Canada tend to be better educated than the general population, but higher learning credentials are often not recognized by Canadian institutions, relegating workers to menial jobs (Amako & MacEachen, 2021). Menial or irregular work is also less likely to provide insurance, further raising potential costs in the event of an accident or mental health event (Jen'nan & Paige, 2018; Martinez-Donate et al., 2017). These financial concerns have been documented to take a serious toll on the psychological wellbeing of immigrants in many studies (Agbemenu et al., 2018; Akinsulure-Smith, 2017; Kamrul et al., 2021).

Isolation and Stress

Immigrants feel the pain of isolation as well. Individuals who choose or are forced to immigrate often leave behind their extended communities when they depart from the host countries. The loss of these social networks engenders feelings of loneliness and estrangement. Separation from extended families causes homesickness and cultural distance, and language barriers make creating new networks difficult in a new country (Kamrul et al., 2021; Tegegne, 2018).

Precarious immigration status may be an additional cause for stress. Immigrants may be in the country illegally, on a temporary stay, as a refugee, or in the process of gaining citizenship (Akinsulure-Smith, 2017; Martinez-Donate et al., 2017). Martinez-Donate et al. (2017) investigated varying healthcare utilization among individuals both legally and illegally working as agricultural laborers in the American Southwest.

Unsurprisingly, the study revealed diverging patterns of utilization. In the same study, subjects reported the persistent fear of detainment and deportation as a significant fear in their daily lives. It should be noted that this fear also extends to family and friends. These fears engender feelings of insecurity and uncertainty in the population that erodes mental health (Akinsulure-Smith, 2017). Olukotun et al. (2019) echoed these findings, revealing similar patterns among undocumented female migrants.

Parenting and Family

Parenting woes are another oft-cited source of stress. While being a parent is not an easy task for any population, immigrant communities, again, are at heightened risk. Financial burdens of parenting are augmented by low socioeconomic status (Agbemenu et al., 2018; Amako & MacEachen, 2021; Kamrul et al., 2021). Furthermore, the constant tension between traditional parenting approaches and host culture norms place immigrant children in a precarious situation (McCann et al., 2018). These children often find themselves caught between host country institutions and parents who struggle to acculturate. Children may struggle with competing identities or difficulties in school and thus act out in ways that challenge their parents (Kim et al., 2018).

Marriage and family tensions can be a significant stressor for immigrants. Problems with money, parenting, and the stress of relocation place strain on marital relations. Spousal abuse and spousal separation have been recorded at heightened rates among immigrant populations (Akinsulure-Smith, 2017). Wang (2020) examined immigrant families and noted the significant correlation between family instability and increased rates of healthcare utilization. Although Wang (2020) examined Asian

immigrants, Kpanake (2016) suggested that this is not an isolated pattern among Asian communities.

Trauma

The immigration experience may be a traumatic experience for new arrivals. Some immigrants are relocating as refugees or are fleeing unstable or violent situations in their country of origin (Woodgate & Busolo, 2018). These individuals may have experienced significant violent or destabilizing events in their journeys from home. Many left behind families or were separated from families and loved ones in the process (McDonough & Colucci, 2019).

These traumatic experiences may never fully heal. One study of immigrant youths recorded extremely high and persistent rates of posttraumatic stress among the subjects, as high as 90% (Anderson et al., 2017; Endale et al., 2020). Even after arrival in the host country, stressful situations abound. New arrivals may be subject to intrusive and dehumanizing border inspections, detentions, and possible deportation (Enos, 2019).

The recent COVID-19 pandemic has yielded interesting insights into the vulnerabilities, both mental and physical, of immigrants. Amoako and MacEachen (2021) examined African immigrants in Toronto and investigated their experiences throughout the COVID-19 pandemic. Immigrants were at heightened risk of catching the virus due to overcrowding in low-income tenements. Poor ventilation as well as high density increased both rates of disease and stress. This study highlights the multi-dimensional nature of immigrant vulnerability. Endale et al. (2020) investigated the effects of COVID-19 on refugee children. Already at increased risk for mental health issues, these

children saw their community center close as a result of the pandemic and subsequent lockdown. Although the center provided online services through 2020 and 2021, it remained a strain on the population it served.

Compounding Concepts

Although these stressors are common among first-generation immigrants, research suggests that the severity diminishes over time and with subsequent generations. Bauldry and Szaflarski (2019) examined the physical and emotional symptoms of stress among immigrant populations. The researchers found a strong correlation between discrimination and physical and mental health issues. However, they found that many of these effects were reduced in second-generation immigrants, who saw symptoms, especially physical symptoms, lower from the previous generation. This research indicated that as the communities acculturate, the stress of immigration status lessens. Escamilla and Saasa (2020) echoed these results, with the added observation that the effect of improved mental health was higher in men than women. These findings have been echoed by other sources, with the qualification that it Is not the case for all ethnicities (Kim et al., 2018).

Saasa et al. (2021) identified social and economic exclusion not only as stressors unto themselves, but also a compounding variable in mental health. Social isolation and poverty exacerbated many of the existing stresses of immigrant life. It is useful, therefore, to conceptualize these stressors not in isolation of one another, but in combination. Indeed, these stressors often exist in tandem, and there is a synergizing effect that amplifies each in turn.

These sources of mental strain and trauma predispose immigrant populations to mental health symptoms, including insomnia, depression, anxiety, memory loss, bouts of sadness, and anger. Symptoms may manifest physically as well with loss of appetite, headaches, high blood pressure, and blurred vision (Akinsulure-Smith, 2017). Even with symptoms, however, individuals may still avoid care. For some, the stigma represents an insurmountable barrier. Malazarte et al. (2021) investigated mental health treatment in African immigrants and reported a significant belief that self-treatment is more desirable than seeking professional help. The data also suggested that with more severe symptoms, treatment is likely. In some cases, avoidance of care has little to do with culture or need but is a practical strategy to avoid detection. Amuedo-Dorantes and Antman (2017) found among illegal immigrant populations that avoidance of care stemmed from a fear of deportation.

Healthcare Utilization

Need for care is the largest single variable in predicting healthcare utilization, and acute health symptoms are a direct manifestation of that need. Given the heightened rates of mental health issues, one would expect high rates of mental health utilization among immigrants seeking aid from public health institutions. However, treatment of mental health issues is not solely the prerogative of public health institutions. Research has shown diverse approaches to mental health treatments among immigrant populations that often fall outside of the scope of traditional Western approaches (Isaak et al., 2020; Wohler & Dantas, 2017).

Immigrants may not take full advantage of the breadth of healthcare options available to them. Islam et al. (2017) found that immigrant families tended to restrict their healthcare visits to the family doctor instead of exploring treatments from a variety of specialists, reflecting limited engagement due to both inadequate knowledge and trust of the broader healthcare system. Davis et al. (2017) also found chronic distrust among the population.

Cultural Practices and Healthcare Use

Many immigrant communities use the formal healthcare system as a last resort. Due to high costs and mistrust in the system, immigrants may retreat into more traditional forms of treatment before going to a doctor. Chao et al. (2019) investigated attitudes and approaches to healthcare among Asian immigrants in New York City. The results showed a low rate of formal hospital care among new arrivals and individuals who were not adequately integrated into the community. These individuals were more likely to utilize traditional Eastern or homeopathic treatments for illnesses than their better-integrated neighbors. These results support earlier research by Akresh (2009), who observed health utilization patterns among Hispanic and Asian immigrants in the United States. Asian immigrants were found to be three times as likely as Hispanic immigrants to use homeopathic and traditional treatments.

Mental healthcare adds another dimension to care. Because physical ailments are more obvious to notice, diagnose, and treat, immigrants are more likely to trust treatments from doctors than mental health professionals (Wohler & Dantas, 2017). When struggling with psychological issues, ethnic minorities tend to turn first to

community support and treatment. Many prefer to seek treatment among their own communities or in traditional ways. Isaak et al. (2020) found that there was a strong preference among First Nation's people toward traditional counseling rather than Western approaches. There was a widespread belief that Western approaches to healing were incompatible with the traditions of the tribe (Wohler & Dantas, 2017). This tendency has led some researchers to advocate blended professional-community systems of care, utilizing a model of mental health treatment that takes advantage of both Western and traditional approaches to mental healthcare (Oppenheim et al., 2019).

Community Support

Community support is a critical component of mental health treatment among immigrant populations. With limited social capital in wider society, immigrant populations tend to rely heavily on their communities for mental health support, as was the case with West Africans examined in New York City (Akinsulure-Smith, 2017). Often the "first line of defense" are family, community, and religious organizations rather than mental health professionals (Agbemenu et al., 2018). Immigrants and ethnic minorities have shown a preference for informal, community-based counseling rather than medical professionals. Some ethnic groups, such as First Nation's peoples in Canada, have traditional modes of mental health counseling that are more trusted than state-sponsored treatments (Isaak et al., 2020). Bauldry and Szaflarski (2019) also found strong social capital correlated with management of stress symptoms, indicating ameliorative effects of community support. It should be noted that this preference

towards informal treatment means it is rather difficult to obtain accurate data on mental health treatment rates among many of these communities.

Those who do not seek community-based therapies and treatments may utilize the formal system and seek out counseling or therapy from medical professionals. This usually involves overcoming a significant number of barriers (Adekeye et al., 2018; Brow et al., 2020; Tulli et al., 2020). Mental healthcare is often not a single-session treatment, but rather requires sustained care over time. Andersen (1995) argued whether or not a patient maintains care over a longer period depends on their perception of the efficacy of care. A patient who is happy with their medical professional and sees improvement in symptoms will likely continue to attend, while those who do not see improvement or are uncomfortable with the process may stop going prematurely. Some may believe the care is inadequate due to a cultural antipathy for psychoactive medicines (Akinsulure-Smith, 2017). Others display a general mistrust of governmental organizations, especially those who are undocumented or otherwise in tension with institutions (Cha et al., 2019).

Immigrant responses are often tentative. Akinsulure-Smith (2017) examined mental healthcare utilization among African immigrants in New York City. Through structured interviews, the author identified major stressors, treatments, and responses to those treatments. The majority of the subjects utilized community-based support systems through family and religious ties. Of the 38 individuals interviewed, only two utilized the formal healthcare system, and both had negative responses to treatment, expressing the inadequacy of the approach and dislike of medication. These data echo other research that

has identified severe need and hospitalizations as significantly negatively correlated to positive experiences in the healthcare system and continued care (Bamvita et al., 2018).

Research is unclear whether these poor mental health responses are the norm. There is a lack of research about the long-term efficacy of cross-cultural mental health treatments, especially among African immigrant populations. However, data suggest traditional healthcare elicits a positive response from immigrant populations more generally. Among Hispanic immigrants, Davis et al. (2017) found that a positive experience of care can generate a positive feedback loop. The research found that while immigrant groups initially had a lower overall perception of quality of care and suspicion of the healthcare system, those perceptions reversed after receiving treatment. Immigrants were more likely to perceive the healthcare system in a positive light and were thus more likely to seek care in the future.

Repeated Care

Positive experiences are critical in ensuring continued care. Bamvita et al. (2018) examined the factors that led to positive experiences with patients. The data showed that regular care and having a care manager were correlated with better perceived outcomes. That is, patients who had a regular relationship with a trusted professional ensured a level of comfort and trust.

This research fits into an overall pattern of work that highlights the importance of trust, personal connection, and continued contact between healthcare providers and immigrant and ethnic minority populations. The research demonstrates a persistent concern among immigrant communities with confidentiality and trust, which can be

largely mitigated by having repeated interactions with trusted professionals (Brow et al., 2020; Hendrie et al., 2020; Kamrul et al., 2021; McCann et al., 2018). Other studies have demonstrated similar findings. Bamvita et al. (2018) and Islam et al. (2017) found that groups utilize family physicians and healthcare providers with whom they have regular contact with over specialists and unknown care providers.

Summary and Conclusions

Given the long history of the Andersen (1995) model and its continued utilization in understanding healthcare outcomes, researchers have explored the factors that influence healthcare utilization among immigrants and other ethnic minorities in the United States. This research has explored the major predisposing factors that affect immigrant groups, including demographic information such as age, gender, and ethnicity. These factors have been identified as significant. The literature has also identified culture as a significant factor that modifies predispositions to care. Culture may encourage or discourage care depending on conceptualizations of health and wellbeing. Resources and barriers to utilization unique to immigrant populations have been identified and impact outcomes measured. Need and the factors that strongly influence healthcare needs have also been explored. Utilization patterns have been shown to differ across ethnic and immigrant groups, especially compared to the general population. Finally, the outcomes of that utilization as well as potential improvements to national healthcare institutions have been recommended.

The focus population for this study was sub-Saharan African immigrants in Baltimore. The focus of much recent literature has been other ethnic groups, including

Asian (Akresh, 2009; 2018; Chao et al., 2019; Shafeek & Driver, 2020) Hispanic (Akresh, 2009; Shafeek & Driver, 2020), or Middle Eastern (Ichou & Rivenbark, 2020) groups. Recent research on African immigrants has been conducted globally in Asia (Xiong et al., 2021), Canada (Amako & MacEachen, 2021; Boukpessi et al., 2021), or other regions of the United States (Adekeye et al., 2018; Agbemenu et al., 2018; Ahad et al., 2019; Akinsulure-Smith, 2017; Malazarte et al., 2021; Saasa et al., 2021).

Recent research has applied Andersen's (1995) model to African immigrants seeking physical health care (Ko et al., 2019). Saasa et al. (2021) also utilized the Andersen model to understand African immigrant mental healthcare utilization. This study differs from the current research in several ways. Saasa et al. utilized web-based surveys to gather data on healthcare utilization, whereas I utilized face-to-face interviews, allowing for more in-depth answers and follow-up questions. Secondly, Saasa et al. examined African immigrants from across the nation. Having a wide sample allows for generalized data but does not allow the researcher to understand region-specific dynamics in the same way. Baltimore is a major coastal U.S. metropolitan city and, as such, patterns of utilization may differ from the Midwest or South. In Chapter 3, I discuss the methodology utilized to conduct the current study.

Chapter 3: Research Method

The goal of this qualitative study was to explore the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore. The rationale for undertaking this qualitative study was to explore the unique experiences of sub-Saharan African immigrants in the United States because their numbers are increasing rapidly. Out of the 40 million immigrants in the United States, slightly more than 2 million are from sub-Saharan Africa (Fazel-Zarandi et al., 2018). The research problem that was addressed in this study was the lack of mental health service utilization and barriers to mental health care among the sub-Saharan African immigrant population (Ayele et al., 2020; Escamilla & Saasa, 2020; Saasa et al., 2021). Chapter 3 focuses on outlining the precise methodologies selected to explore this research problem. The main sections in Chapter 3 include the research design and rationale, role of the researcher, methodology, issues of trustworthiness, and summary.

Research Design and Rationale

The qualitative study was guided by one central research question that enabled me to address the purpose of the study, which was to explore the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore. The research question was as follows: What are the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore?

The phenomena of interest were mental health service access, mental health service utilization, and mental health barriers. These phenomena were assessed within the context of current experiences of sub-Saharan African immigrants living in Baltimore.

The selected research method for this study was a general qualitative inquiry. According to Allan (2020), qualitative research entails gathering and analyzing nonnumerical information such as audio, video, and text to comprehend experiences, views, and concepts. A qualitative research approach can be employed to gather in-depth insights into a research problem as well as to generate new notions for research (Allan, 2020). Qualitative research is typically employed in the social sciences and humanities, in subjects like history, health sciences, education, sociology, and anthropology (Guest et al., 2020).

The qualitative method was selected as it was ideal for the exploration of a phenomenon that required the subjective opinions, perceptions, and experiences of participants (Merriam, 2002). A quantitative approach is ideal for the exploration of a phenomenon through statistical data to address a measurable or testable phenomenon. Researchers employ quantitative approaches to address a testable phenomenon that can be addressed with a hypothesis and descriptive or inferential statistics (Alexander, 2021). For this study, the use of a quantitative methodology was not ideal, as the aim was not to measure a phenomenon or collect testable data. Instead, the qualitative methodology facilitated an exploratory approach, enabling me to collect rich data regarding the topic of this project. The qualitative approach was ideal for gathering data through interviews that provided insights that directly addressed the research questions.

I chose a generic research design for this study. Also referred to as the generic qualitative study, this research design is clearest when described in the negative. This research approach is not guided by an established or explicit set of theoretical

assumptions in the form of one of the recognized qualitative research designs such as ethnography, grounded theory, and phenomenology (Caelli et al., 2003). Generic qualitative research designs do not adhere to any of the established qualitative research approaches (Caelli et al., 2003). In addition, according to Caelli et al. (2003), a generic qualitative method is employed by researchers to discover and comprehend a process, phenomenon, worldviews, and perspectives of the individuals involved. This method is a descriptive approach used to explore how people make meaning of a situation or a phenomenon based on the most appropriate technique of finding answers for the questions under assessment (Kostere & Kostere, 2021).

The generic research design is used for describing and discussing a phenomenon from the perceptions of participants (Kostere & Kostere, 2021). Using the generic design, data can be gathered through interviews, surveys, or other methods that directly gain the participants' reflections (Merriam, 2002). The generic research design was the most fitting approach for the study, as it was useful in exploring the phenomena of interest, including mental health service access, mental health service utilization, and mental health barriers, within the context of current experiences of sub-Saharan African immigrants living in Baltimore. I gathered research data from participants using semistructured interviews, which aligned with the requirements of generic qualitative research. Other qualitative research designs, encompassing a case study, action research, historical design, grounded theory, ethnographic, and phenomenology, were assessed and deemed unfit for addressing the purpose of the current study.

Role of the Researcher

The role of the researcher in a qualitative study is to try to access the feelings and thoughts of the study respondents (Allan, 2020). Accomplishing this is not easy, as it entails asking people to speak about things that might be very personal to them (Allan, 2020). At times, the experiences being assessed are fresh in the respondent's mind, whereas in other scenarios, recalling previous encounters can be challenging (Guest et al., 2020). Nonetheless, when data are gathered from human participants, the key role of the researcher is to protect those individuals and their data. Allan (2020) added that mechanisms for such protection must be explicitly articulated to respondents and must be approved by a pertinent research ethics board before the study commences.

The responsibility of the researcher as an observer, participant, or observer-participant in generic research is to be the main instrument of data gathering and analysis and to triangulate the results from fieldwork (Bellamy et al., 2016). Thus, my first role was to seek approval for the study from Walden University's Institutional Review Board (IRB). The approval also included the use of the suggested data collection approach, semistructured interviews. I formulated the semistructured questions that guided the data collection process. After obtaining IRB approval (Approval No. 06-30-22-0079283), I embarked on the data collection process. Data were gathered from eight to 12 sub-Saharan African immigrants in Baltimore who have experienced mental health conditions and barriers and have sought relevant healthcare services. Before collecting data, I made sure to obtain informed consent from the targeted participants, as the study was entirely voluntary. Using informed consent forms, I explained to the participants the purpose of

the study, the risks that might be involved, and the benefits of participating. I further utilized the informed consent forms to notify the respondents of their privilege to withdraw from the study at any stage or moment during the data gathering and analysis process. In these forms, I also clarified how the respondents' confidentiality would be safeguarded both during and after the study. Participants were given adequate time to reflect on all aspects of the study as outlined in the informed consent forms. I only collected data from participants who signed the informed consent forms.

Data were collected through one-on-one, semistructured interviews with each participant. It was my responsibility to first select relevant participants. I achieved this through purposeful sampling, which allowed me to choose only sub-Saharan African immigrants in Baltimore who had experienced mental health conditions and barriers and have sought relevant healthcare services, as these individuals had direct experience with the phenomenon under investigation and would be able to provide relevant and sufficient information to answer the study's research question. Then, I organized and managed the interview sessions based on the convenience of the participants.

Another key role of the researcher in generic research is to completely understand respondents' detailed descriptions of their experiences concerning the phenomena and present the results by the use of mutual themes and subthemes (Caelli et al., 2003). I focused on understanding respondents' meanings and perspectives regarding their experiences of utilizing mental healthcare services while asking guiding questions as well as encouraging them to assess and reflect on their experiences. While formulating the

data collection tool (i.e., semistructured questions), I took into consideration the possible biases that may arise during the study process and strove to address them.

Methodology

Participant Selection Logic

Population

The target population for this study included sub-Saharan African immigrants living in Baltimore who had experienced mental health conditions and barriers and had sought relevant healthcare services. A little over 2 million of the 40 million immigrants in the United States are from sub-Saharan Africa (Fazel-Zarandi et al., 2018). While this population is small, it is rapidly growing. Baltimore was selected for this study because it is a large metropolitan region with a significant population of sub-Saharan African immigrants who engaged in African cultural, spiritual, and social activities.

Sampling Method

I employed a purposeful sampling approach to select the study participants. According to Campbell et al. (2020), purposeful sampling – also referred to as purposive, subjective, selective, or judgmental sampling – is a type of nonprobability sampling where investigators depend on their distinct reasoning when selecting members of the population to engage in their studies. Purposeful sampling is broadly employed in qualitative studies for the determination and selection of data-rich scenarios linked to the phenomena of interest (Campbell et al., 2020). Researchers usually consider that they can acquire a representative sample by the use of sound reasoning that will lead to saving resources and time (Campbell et al., 2020).

Purposeful sampling is divided into six categories, including a typical case, a deviant or extreme case, critical case, homogeneous sampling, maximum variation or heterogeneous sampling, and theoretical sampling (Suri, 2011). This study was based on a homogenous sampling approach that focuses on one subgroup in which all sample members are identical (Suri, 2011). Purposeful homogeneous sampling was effective in achieving this because this approach allows the investigator to depend on their own judgment when selecting members of the population to participate in a study (Ghaljaie et al., 2017). It enabled me, as the researcher, to only select sub-Saharan African immigrants in Baltimore who had experienced mental health conditions and barriers and had sought relevant healthcare services.

Sample Size

Generic qualitative researchers consider that a comprehensive, high-quality analysis of a small number of scenarios is the most suitable approach for this kind of assessment (Caelli et al., 2003). One of the key roles of a researcher in generic research is to completely understand respondents' detailed descriptions of their experiences concerning the phenomena and present the results by the use of mutual themes and subthemes (Caelli et al., 2003). Caelli et al. (2003) indicated that the saturation point is contingent on whether the investigator is looking for big picture metathemes or more detailed, controlled, and dissimilar themes.

Saturation could be achieved by accomplishing the first planned 12 interviews or even fewer if the investigator is assessing simpler themes or metathemes (Caelli et al., 2003). Based on these notions, the purposeful sampling approach was used to recruit

between eight and 12 sub-Saharan African immigrants in Baltimore who have experienced mental health conditions and barriers and have sought relevant healthcare services. I achieved the saturation point for this study by interviewing eight respondents.

Selection Criteria

Employing a purposeful sampling method in the study required having some underlying selection criteria. I aimed at only assessing sub-Saharan African immigrants in Baltimore who had experienced mental health conditions and barriers and have sought relevant healthcare services. These were the most appropriate participants for this study as they were the only ones who could help in answering the formulated research question. As a result, the participants chosen to be interviewed were able to provide descriptions of their experiences with the phenomena of interest, namely mental health service access, mental health service utilization, and mental health barriers. The selected participants had migrated into the United States from the sub-Saharan African region. Sub-Saharan African is, geographically, the region of the African continent that lies south of the Sahara (Wang & Dong, 2019). Out of the 54 countries in Africa, as per the United Nations, only five are not in the sub-Sahara region: Tunisia, Algeria, Morocco, Libya, and Egypt (Wang & Dong, 2019). Immigrants from these five countries were not included in this study. The participants for this study were further required to have lived in Baltimore, Maryland, for at least 1 year and be willing to speak about their experiences in utilizing mental health services.

Participant Recruitment

Before beginning this study, I sought approval from Walden University's IRB. After approval, I sought informed consent from relevant participants for this study. This study was entirely voluntary, meaning that I assessed individuals who were willing to participate in the study. Using the informed consent forms, I (a) explained to the participants the purpose of the study, the risks that might be involved, and the benefits of participating; (b) notified them of their privilege to withdraw from the study at any stage or moment during the data gathering and analysis process without repercussion; and (c) clarified how the respondents' confidentiality would be safeguarded both during and after the study. I reached potential participants through community organizations in Baltimore that focused on the mental wellbeing of sub-African immigrants.

To locate participants for this study, I posted flyers around social gatherings, such as cultural groups and churches' information boards. Individuals who responded to the flyer indicating interest in participating in this study were contacted via telephone or email and were provided with more details concerning the study as well as an informed consent form. Only those who agreed to the terms of the study and agreed to the informed consent form were invited for interviews. I conducted one-on-one interviews with the interested respondents. These interviews were guided by a set of semistructured interview questions. I conducted the interviews from my office via the online videoconferencing platform Zoom, where confidentially was maintained. Individual participants gave me the time that was most convenient and confidential for them. There was no cost of

transportation incurred by the participants. With participant consent, the interview was recorded for transcription purposes.

Instrumentation

To collect data for this study, I created a semistructured, one-on-one, in-depth interview guide (see Appendix), which was assessed by an expert panel. For the research design (generic qualitative assessment), I conducted semistructured interviews. The selection of semistructured interviews was made based on the investigative principle of generic qualitative research. The semistructured interviews were appropriate for this study as they provide a framework for gathering rich exploratory data based upon the experiences of the participants. A semistructured interview allows for a guiding question that is accompanied by probing questions based on the responses of the participants (Mahat-Shamir et al., 2021). The use of the semistructured interview guide greatly aided in gathering the perceptions of participants in terms of ensuring that the questions provided to participants aligned with the research question and the purpose of this study, which was to explore the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore.

The semistructured interview guide did not have a strict set of formalized questions and did not include a straightforward question-and-answer format. Instead, the interview guide enabled me to ask more open-ended questions to facilitate discussion during the interviews. The interview guide was developed based on the key concepts of the study, including mental health service access, mental health service utilization, and mental health barriers. The semistructured questions were closely linked to the research

question because the aim of conducting the semistructured interviews was to effectively answer the developed research question. The interview question was formulated based on relevant, published literature appraised in Chapter 2, which identified the phenomena under study, mental health service access, mental health service utilization, and mental health barriers, as pertinent to answering the research question.

Procedures for Recruitment, Participation, and Data Collection

To locate participants for this study, I posted flyers around social gatherings, such as cultural groups and churches' information board, as well as social networks like Facebook and LinkedIn. Interested respondents were issued an informed consent form, detailing the purpose, benefits, and risks of the study as well as the procedures of withdrawing. The study was entirely voluntary, and each respondent could withdraw at any stage or moment during the data collection and analysis procedure. Willing and interested respondents were asked to read through the consent form and agree to all aspects of the study. I achieved this via email. Willing respondents were required to sign the consent form and return it to me via email. After receiving the first signed consent form, I scheduled the first interview. I completed eight interviews at the end of the data collection process.

All respondents in this study were interviewed on a one-on-one basis viz Zoom or telephone. Before starting the interview, I downloaded the Zoom software and ensured that respondents' confidentiality would not be violated. I then scheduled a meeting with each respondent in the app and sent out invitations to the respondents. As the host, I admitted each respondent to the meeting. Once I started the interview with each

respondent, I asked for permission to record the interview. Additionally, I took note of body language or auditory clues. Participants were also asked to choose either to be interviewed via phone or Zoom. I also ensured that the participants were seated where they could comfortably express themselves without being heard by someone. Moreover, I ensured that my audio recording program was working efficiently before I began the interview. All respondents were interviewed in English with the use of a semistructured interview guide.

During the data collection process, I reviewed the purpose and nature of the study, reminded the respondents about their consensus to participate, addressed any respondents' concerns, and answered questions that emerged regarding the study. I further explained to the participants the compositions of the semistructured interviews, the processes of the interviews, as well as the probing questions determined by the respondents' data regarding the phenomena of this study. It was also my role as the researcher to inform the respondents of ethical protection and confidentiality before the commencement of the interviews.

Each interview took approximately 45 to 75 minutes. This allowed adequate time for every respondent to provide his or her experiences in utilizing mental health services. After the interviews, every respondent was debriefed, which entailed a brief restatement of confidentiality and a depiction of future contact for the member checking procedure. The audio-recorded interviews were delivered to a reputable and approved data transcription agency in Baltimore for the transcription process. To safeguard the confidentiality of the respondents, I did not disclose any identifying information to the

transcription organization. I assigned each participant a unique identifier in place of their name. The transcription organization signed a mandatory transcriptionist confidentiality contract before receiving the audio-recorded interviews. After transcription, the organization returned to me the electronically transcribed interview audio-recordings as well as a hard copy of the interview audio-recordings. I then summarized each interview transcript by each question and sent the summary to every respondent for member checking and feedback. This process provided the respondents the chance to evaluate their experiences and delete, alter, or add information.

Data Analysis Plan

The collected qualitative data were analyzed using Braun and Clarke's (2006) six-step thematic analysis. The six steps comprise familiarization, coding, generating themes, evaluating themes, describing, and naming themes, and writing up (Braun & Clarke, 2006). I prudently followed these six steps during the analysis of the collected and transcribed interview data. I first reviewed the audio recording and the verbatim transcripts. In doing this, I gained clarity of the interview data for easy comprehension and interpretation of these data. The next step was coding to formulate themes and subthemes. The formulation of themes among respondents was determined among distinct respondents' cases before the categorized themes. After the assessment of distinct scenarios, the focus was not changed to appraising the group association and repeating themes that might be pertinent to a more substantial part of respondents. I explored the discrepant scenarios and responses to identify their distinct importance, which was vital in improving the comprehension of the meaning of the utilization of mental healthcare

services among sub-Saharan African immigrants living in Baltimore. I used NVivo 12 Pro for the organization and management of qualitative data. The software further facilitates the organization of transcribed data into themes and subthemes, which are interpreted and presented in Chapter 4.

Issues of Trustworthiness

Trustworthiness in qualitative research entails the level of confidence maintained in the study (Cloutier & Ravasi, 2021). According to Amin et al. (2020), trustworthiness is equivalent to the reliability, validity, and objectivity of quantitative studies. Unanimously, quantitative, and qualitative investigators employ detailed empirical approaches meant to affirm the trustworthiness of their clinical outcomes (Amin et al., 2020). Cloutier and Ravasi (2021) indicated that trustworthiness in qualitative studies is evaluated using four designed criteria: credibility, transferability, dependability, and confirmability. Each of these is described in the following subsections.

Credibility

Credibility refers to a qualitative trustworthiness principle, which is likened to internal validity in quantitative studies (Amin et al., 2020). Credibility necessitates determining that the results of a qualitative study are trustworthy from the viewpoint of the study respondents (Cloutier & Ravasi, 2021). For this study, credibility was determined via lengthy engagement with the respondents during data gathering. I strove to immerse myself into the respondents' cases to acquire insight into the context of the study. My lengthy engagement with the respondents to undertake one-on-one interviews was significant in enhancing confidence. Spending adequate time with the respondents

enabled me to comprehend the key concerns which might impact data quality as well as improve trust with the respondents. After transcription, I summarized each interview transcript by each question and sent the summary to every respondent for member checking and feedback. This approach also guarantees credibility.

Transferability

Transferability is described as the extent to which the audience/reader can transfer the study outcomes to other meaningful individuals and contexts (Cloutier & Ravasi, 2021). To guarantee the transferability of the findings in the study, I provided a detailed explanation of the data collection and analysis procedures. I defined the context of the study, research methodology, and design and provided the respondents with a comprehensive explanation of the information to be transferred to other contexts and groups. I attained transferability through the use of a comprehensive description of the study details.

Dependability

Dependability in qualitative research ensures that the study outcomes are dependable and can be repeated (Cloutier & Ravasi, 2021). Dependability is regarded as the standard under which a qualitative study is executed, appraised, and presented (Cloutier & Ravasi, 2021). Dependability further facilitates the investigator's capability to comprehend the methodologies employed and their significance (Amin et al., 2020). For this study, dependability was achieved by following the appropriate procedures of data collection and analysis.

Confirmability

Confirmability in qualitative studies can be likened to objectivity in quantitative research. Confirmability is the level at which the clinical outcomes transpire from the respondents' experiences and viewpoints and is supported by the data gathered and appraised by the researcher (Cloutier & Ravasi, 2021). For this study, confirmability was established by making accessible the supportive study data which enable others to validate the study arguments and interpretations. I used a substantial quantity of word-for-word quotations from each respondent during the data analysis process. I further established confirmability by checking whether the study interpretations and conclusions were pertinent to the literature review.

Ethical Procedures

Various ethical procedures were considered in this study. The first ethical process was to seek approval for the study from Walden University's IRB. Approval from this board implies that the study meets the needed guidelines for an institution-supported study dissertation. The respondents in this study participated voluntarily. To guarantee this type of participation, I formulated informed consent forms that detailed the purpose as well as the potential benefit and risks of this study. Only willing and interested participants were recruited and interviewed. At no point during the collection, transcription, analysis, interpretation, and presentation of data, did I disclose any identifying details from the participants. This was instrumental in maintaining the confidentiality of the respondents. The study participants had the right to withdraw at any stage or moment during the data collection and analysis process without repercussion.

The study was undertaken in conformity with the data storage and safety processes, which includes storing data for 5 years in locked and password-secured files, as required by Walden University IRB. I kept a sequential research journal with respondents' contact details, notes for precise objectives, summarized issues, follow-up concerns, and other applicable data. I maintained the collected data on my computer to which only I had access. I will also keep the raw data files for 5 consecutive years before permanently removing them from the computer system and destroying the paper documentation. Every respondent allocated a pseudonym for the study to ensure that their confidentiality and safety were maintained.

Summary

I utilized the general qualitative methodology for the current study. The qualitative methodology facilitates an exploratory approach, enabling the researcher to collect rich data regarding the topic of interest. The qualitative approach is ideal for gathering data through interviews that provide insight to directly address the research questions. The generic research design was considered and selected for this study. The generic research design is clearest when it is described in the negative. This research approach is not guided by an established or explicit set of theoretical assumptions in the form of one of the recognized qualitative research designs such as ethnography, grounded theory, and phenomenology (Caelli et al., 2003). The generic research design was the most appropriate method for this study as it was useful in exploring the phenomena of interest, including mental health service access, mental health service utilization, and mental health barriers, within the context of the current experiences of sub-Saharan

African immigrants living in Baltimore. Data were gathered from participants using semistructured interviews, which aligns with the requirements of generic qualitative research.

The target population for this study included sub-Saharan African immigrants. Purposeful sampling was used to recruit and select between eight and 12 sub-Saharan African immigrants in Baltimore who had experienced mental health conditions and barriers and have sought relevant healthcare services. For the research design (general qualitative assessment), semistructured interviews were used for data collection. The semistructured interviews were appropriate for this study as they provide a framework for gathering rich exploratory data based upon the experiences of the participants. The composed qualitative data were analyzed using Braun and Clarke's (2006) six-step thematic analysis. I used NVivo 12 Pro to organize and manage the qualitative data. The software also enabled the organization of transcribed data into themes and subthemes, which are interpreted and presented in Chapter 4. Chapter 4 also includes a detailed description of the study findings as well as demographics, data gathering and data analysis, and trustworthiness substantiation.

Chapter 4: Results

Sub-Saharan African immigrants account for 4.5% of the United States' 40 million immigrants (Fazel-Zarandi et al., 2018). Although the proportion of immigrants from sub-Saharan Africa is small, their numbers are rapidly growing, and their mental health impacts the overall health of the United States. Studies have shown low levels of mental health service-seeking behaviors among immigrants from sub-Saharan African immigrants (Fanfan & Stacciarini, 2020; Haffizulla et al., 2020; Louis et al., 2017), and their experiences in accessing mental health services are under-researched. This qualitative study explored the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore. The following research question was identified to achieve this study purpose: What are the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore?

In Chapter 4, I describe the thematic analysis approach guided by Braun and Clarke (2006). This chapter is organized into the following subsections: setting, descriptive data, data collection, data analysis, trustworthiness of data, results, and summary.

Setting

The study included eight adult immigrants from sub-Saharan Africa living in Baltimore who have experienced mental health conditions and barriers and had sought relevant healthcare services. I selected Baltimore because it is a large metropolitan region with a significant population of sub-Saharan African immigrants who engage in African cultural, spiritual, and social activities. Due to the COVID-19 pandemic and potential risk

of spreading the illness, I conducted semistructured individual interviews via Zoom with each of the eight participants. The interviews were conducted in my office using the video camera function on the Zoom meeting platform, which gave me the opportunity to gather details of participants' nonverbal communication, such as facial expressions and body language. I was alone in my office during each video call, and all participants indicated that they had sufficient privacy during the interviews.

Descriptive Data

Using purposeful sampling, I selected eight respondents to participate in the semistructured interviews. The sample size was guided by the requirements of data saturation as described by Caelli et al. (2003). Eight participants (see Table 1) took part in the study, five (62.5%) of whom were female, and three (37.5%) of whom were male. As shown in Table 2, the interview transcripts ranged from nine to 17 pages, while the average length was 12.5 pages. Audio interviews were between 45 and 60 minutes, with an average of 52.5 minutes.

Table 1

Descriptive Data

Participant	Sex	Country of origin
Participant 1	Male	Nigeria
Participant 2	Female	Cameroon
Participant 3	Male	Nigeria
Participant 4	Male	Nigeria
Participant 5	Female	Nigeria
Participant 6	Female	Cameroon
Participant 7	Female	Cameroon
Participant 8	Female	Nigeria

Table 2

Length of Interview Audio and Transcripts

Participant	Length of transcript in pages (Times New Roman 12, double spaced)	Length of an audio interview (minutes)
Participant 1	11	48
Participant 2	17	60
Participant 3	9	45
Participant 4	10	46.5
Participant 5	12	48.5
Participant 6	14	53
Participant 7	13	51.5
Participant 8	14	53

Data Collection

I obtained approval for this study from Walden University's IRB before collecting data. I posted a recruitment flyer in communities and social gatherings with large populations of immigrants from sub-Saharan Africa. For inclusion, I enquired about (a) being an immigrant from a country within sub-Saharan Africa, (b) being a resident in Baltimore, and (c) having sought or received mental health services. Ten immigrants responded to the research flyer adverts; eight met the selection criteria and provided informed consent to participant in the semistructured interview over 1 month.

I collected participants' email addresses and emailed them the informed consent form for them to read, sign, and email back to me. I then scheduled the interviews. The interviews were conducted at various times of the day based on the participants' availability. In addition to having participants sign the consent form, at the beginning of each interview, I informed participants about the recording of the interviews and asked for their verbal consent to proceed. All participants provided consent to record. Also, I

asked for demographic information and conducted the interviews via Zoom. The interviews lasted for an average of 45–60 minutes and were recorded using an inbuilt recorder in Zoom.

I utilized a journal to capture their initial impressions, observations, and reflections during the interview. After the interview, I reviewed my journal notes alongside a review of the interview recording. A numerical code (e.g., P1, P2) was assigned to each interview recording to identify participants and maintain confidentiality. I stored the interview recordings and transcripts on a password-protected laptop.

Data Analysis

I utilized a professional service to transcribe the recorded audio using Microsoft Word. Once transcription was complete, I reviewed each transcript for accuracy by comparing it with the audio file. Review of transcripts entailed listening to the audio recording while reading through the transcript. Then, I corrected the transcripts to include omitted data and adjust the misinterpreted words. I then anonymized the transcripts by omitting the names of participants and their health facilities and health providers. Alphanumeric codes (e.g., P1, P2) were allocated to identify the transcripts instead of participants' names. The transcripts were then formatted in Microsoft Word to ensure uniform font and spacing (Times New Roman, font size 12, and double spaced) before analysis.

I followed Braun and Clarke's (2006) six steps for thematic analysis. I conducted data analysis using NVivo 12 qualitative software. I used the six steps followed in the

inductive analysis process, which entails a researcher reading and interpreting raw data to develop codes or concepts (Chandra & Shang, 2019). The six steps are as follows:

1. Data familiarization
2. Initial coding
3. Searching for themes
4. Reviewing the themes
5. Naming the themes
6. Presenting the findings

During the first step, data familiarization, I reviewed all the interview data. The aim was to ascertain that the analysis was centered on the informants' statements. I read and re-read the interview transcripts multiple times to become familiar with the content of the interview transcripts.

During the second step, I carried out initial coding, which refers to grouping excerpts from the transcripts with similar meanings. I ascertained that identified codes were directly related to the informants' opinions of the study phenomenon. As an example of the inductive, initial coding process, consider the following response from Participant 2:

> Because they are undocumented, they shy away from using those (mental health) services. Because they struggled to come to the USA, they do not think they want to expose themselves to the possibility of being arrested and sent back to Africa.

The excerpt above was allocated the code "fear of deportation bars access to services." The participant noted that undocumented immigrants may fail to access mental health

services due to fear of being reported to immigration and deported back home. Through the process of initial coding, I identified a total of 19 initial codes.

During the third step, I searched for themes. I reviewed the initial codes to identify related ones. Related codes were identified when the meaning of the data assigned to them converged by displaying different aspects of the same overarching idea. This initial process of grouping recurring patterns of words and concepts allowed me to identify large groups of similar content. This process also allowed me to label the groups with an overarching theme. Table 3 illustrates how initial clustering codes formulated meaning to form themes.

Table 3

Clustering of Initial Codes to Form Initial Themes

Initial themes	Clustered initial codes
Social norms	Mental illness means madness Curses or supernatural beings cause madness.
Traditional healers and mental health	Traditional healers can cure madness
Religion and mental health	Religion as a solution for madness
Stigma faced by the mentally ill	Isolation of mentally ill Africans
Knowledge and access to services	Immigrants have limited information about mental health services. Mental health information is increasingly available among immigrants
Income and access to services	Unemployment among immigrants Low income among immigrants Competing needs reduce finances for healthcare
Immigrants were not offered insurance	Immigrants were not offered health insurance at work. Immigrants cannot afford private insurance.
Barriers to services among undocumented immigrants	Undocumented immigrants may be unemployed. Undocumented immigrants fear the risk of deportation as they seek health services. Undocumented immigrants lack insurance. Undocumented immigrants may access emergency mental health services.
Language and access to services	Non-English-speaking immigrants English-speaking immigrants with dialects Health facilities have language interpreters

In the fourth step, I assessed identified themes by reviewing them against the interview transcripts. The purpose of the review was to validate the themes against the original transcripts. I engaged in the third round of selective coding, where the themes that were to be related were merged into more encompassing themes containing closely related smaller groups (see Theron, 2020). I identified five themes and took the time to reflect on their meanings to ensure the accuracy of the findings. Table 4 indicates the clustered themes.

Table 4

Clustering of Initial Themes Into Metathemes

Data metathemes	Clustering of initial themes
Stereotyped beliefs and poor health-seeking behaviors	Social norms Traditional healers and mental health Religion and mental health Stigma faced by the mentally ill
Limited knowledge and limited access to services	Knowledge and access to services
Low-income levels and limited access to services	Income and access to services Immigrants were not offered insurance.
Undocumented immigrants have multiple barriers to services	Barriers to services among undocumented immigrants
Low English proficiency and access to services	Language and access to services

The fifth step entailed the definition of themes, where I allocated names to clarify the significance of each theme in addressing the research questions. I achieved a detailed description by integrating all of the findings (Wirihana et al., 2018). I appraised the transcripts, thematic clusters, and final themes several times to identify inconsistencies

and ensure a comprehensive description. I used the themes or metathemes to describe the participants' perceptions of African immigrants' access to mental health services.

The final step included the presentation of the findings. In this step, I detailed the participants' responses to the research questions. In the results section, findings are organized by the five data themes that address the research question. I provide direct quotes from the data to enable the reader to assess each theme's confirmability independently. Below is a brief description of the five themes:

- Theme 1: Stereotyped beliefs about mental health contribute to poor health-seeking behaviors among immigrants from sub-Saharan Africa.
- Theme 2: There is limited mental health knowledge among sub-Saharan African immigrants.
- Theme 3: Low-income levels and lack of health insurance limit immigrants' access to mental health services.
- Theme 4: Undocumented immigrants lack access to mental health services due to fear of deportation.
- Theme 5: Low English language proficiency among immigrants' limits access to mental health services.

Trustworthiness of Data

Trustworthiness in qualitative research entails the level of confidence maintained in the study (Cloutier & Ravasi, 2021). Amin et al. (2020) stated that trustworthiness is equivalent to reliability, validity, and objectivity in quantitative studies. Unanimously, quantitative and qualitative investigators employ detailed empirical approaches to affirm

their clinical outcomes' trustworthiness (Amin et al., 2020). Cloutier and Ravasi (2021) indicated that trustworthiness in qualitative studies is evaluated using four designed criteria of credibility, transferability, dependability, and confirmability.

Credibility

Credibility refers to a qualitative trustworthiness principle likened to internal validity in quantitative studies (Amin et al., 2020). Credibility necessitates determining that the results of a qualitative study are trustworthy from the viewpoint of the study respondents (Cloutier & Ravasi, 2021). I ensured credibility via lengthy engagement with the respondents during data gathering. I immersed myself in the respondents' cases to acquire insight into the context of the study. I conducted one-on-one interviews with each respondent, which enhanced my ability to comprehend the key concerns that might impact data quality and improve trust with the respondents. After transcription, I summarized each interview transcript by each question and sent the summary to every respondent for member checking and feedback. Feedback was received from all the respondents, and transcripts were revised where omissions or errors were noted. The member checking approach guarantees credibility.

Transferability

Transferability is the extent to which the audience/reader can transfer the study outcomes to other meaningful individuals and contexts (Cloutier & Ravasi, 2021). To guarantee the transferability of the findings in the study, I provided a detailed explanation of the processes of data collection and analysis procedures undertaken. In Chapter 3, I defined the context of the study, research methodology, and design and provided the

readers with a comprehensive explanation of the information to be transferred to other contexts and groups. I enhanced the study's transferability by providing a comprehensive description of the study.

Dependability

Dependability in qualitative research ensures that the study outcomes are dependable and can be repeated (Cloutier & Ravasi, 2021). Dependability is regarded as the standard under which a qualitative study is executed, appraised, and presented (Cloutier & Ravasi, 2021). Dependability further facilitates the investigator's capability to comprehend the methodologies employed and their significance (Amin et al., 2020). In this study, dependability was achieved by following the appropriate data collection and analysis procedures as detailed in Chapter 3. Any methodological changes, including the small sample size, are highlighted and discussed in Chapter 5 under the study limitations.

Confirmability

Confirmability in qualitative studies can be likened to objectivity in quantitative research. Confirmability is the level at which the clinical outcomes transpire from the respondents' experiences and viewpoints and is supported by the data gathered and appraised by the researcher (Cloutier & Ravasi, 2021). I enhanced confirmability by making the supportive study data accessible to enable readers to validate the study's arguments and interpretations. I used a substantial quantity of word-for-word quotations from each respondent during the data analysis process. I further establish confirmability in Chapter 5 under the discussion section by aligning the study interpretations and conclusions to pertinent literature review in Chapter 2.

Results

In this section, findings are organized under the data themes. I sought to answer one research question: What are the experiences of sub-Saharan African immigrants accessing mental health services in Baltimore? Through the thematic analysis approach, I identified five themes. In the following section, each theme is described and illustrated with quotes.

Theme 1: Stereotyped Beliefs About Mental Health Contribute to Poor Health-Seeking Behaviors Among Immigrants from Sub-Saharan Africa

Theme 1 discusses the stereotyped beliefs that hinder immigrants of African descent from seeking mental health services. The first stereotype was about African communities' definition or perception of mental health problems. Participants (n = 5) indicated that mental health problems are associated with madness in Africa. For example, Participant 2 reported that mental health problems are equated to madness in their culture, and people dislike the association with madness. Participant 2 stated,

> African immigrants, basically they do not compartmentalize mental health into different subcategories as we do here (in the United States). So, when you talk about mental health, most of them, the first thing that comes to mind is madness. That is why most African immigrants do not want to associate themselves with anything having to do with mental health.

Similarly, Participant 7 indicated that in their African culture, mental health problems are also associated with being crazy. They also pointed out that crazy people face isolation from their community, including family members. Participant 7 stated,

> When we use the word mental in my culture and any African culture, it means the person is somebody crazy. People withdraw. That person would majorly feel isolated, and people do not come around, and they do not have the support. Sometimes they do not have the support of their relatives. Sometimes they do.

The second stereotype addresses the source of madness perceived by African communities. Participants stated that madness in African communities is believed to be a curse from supernatural beings. Some participants further argued that the belief informs the tendency to seek help for mental illness from religious leaders and traditional healers as opposed to modern medicine. For instance, Participant 4 argued that treatment for madness is sought from traditional healers or religious leaders who can offer prayers because someone outside themselves causes it:

> They [Africans] feel that it is madness. They feel that it has been a curse according to that [African] tradition, and they feel that they need prayers, or they need herbs, traditional healers for all that because they feel that it has been done by somebody.

In addition, Participant 5 argued that people with mental health issues are seen as cursed and thus seek help from pastors (religious leaders) and traditional healers. They stated, "Another reason is the stigma that makes them feel like, 'Oh, they are cursed.' So, the only way to resolve their mental health issues is through the traditional doctors or their pastor." Also, Participant 3 argued that people with mental health issues are less likely to seek modern health services due to their beliefs about madness, sharing,

> First of all, nobody wants to feel or expose himself that he is mad because they think somebody (who) has a mental problem is mad. So, they do not tend to seek (help). Even if they have a problem, they are not going to a health institution. They may want to discuss it with an elderly person in the family or go to their church to meet their Pastor.

The underlying beliefs about mental health problems and their source further explain how those with mental health problems are treated in African society. Some participants gave examples of enacted stigma directed at people with mental health problems in African communities. For example, Participant 2 argued that somebody with a history of mental illness in their culture would not find a marriage partner because others would not want to associate with a mad person. They shared the following:

> In my culture, when a lady or a gentleman wants to get married, the first thing they do is do a kind of background check. And if, at a certain point in time, they associate you or a family member even to the third or fourth generation, with when any aspect of madness, that marriage might have many problems because it might not be... The couple might not accept you as a good fit for marriage because they will tell them that, 'This family had a history of madness, so you cannot get married to them because you have the probability of having your spouse mad, or you might have a child that may become mad sometime. (Participant 2)

The other aspect is the internalized stigma among African communities stemming from their beliefs about mental health and its association with madness. Participant 1

argued that people of African descent have internalized stigma associated with mental health problems and fear of isolation. They stated,

> If you exhibit those behaviors (mental health problems), people call you a mad man or a mad woman, a mad girl or a mad boy, and they do not want to deal with you, so that you will be isolated from the entire population. They will say it is some evil spirit or spiritual attack, and the people do not want to help or deal with that person. (Participant 1)

Participant 7 argued that the silence about mental health problems among Africans is due to the fear of being perceived as mad. They stated that such a person faces isolation from the community and has no support. According to Participant 7,

> When we use the word mental in my culture and any African culture, it means the person is somebody crazy. People withdraw. That person would majorly feel isolated, and people do not come around, and they do not have the support. Sometimes they do not have the support of their relatives. Sometimes they do.

In the following quote, Participant 7 further argues that given the underlying beliefs, when people of African descent experience mental health problems, they keep it private. They do not want to be perceived as mad. They shared,

> That is not an issue you discuss in public or the open, what you are going through when it comes to mental health. … When you put it out there, everybody thinks you are a crazy person, a mad man, or a mad woman. So, people keep it to themselves. (Participant 7)

In summary, Theme 1 indicates that stereotypes about mental health exist among people of African descent. The stereotypes link mental health problems to madness, which is linked to curses that cannot be addressed with modern medicine. The fear of madness explains the silence and stigma that those who suffer from mental health problems face. Further, the beliefs about mental health problems shape help-seeking from religious leaders and traditional healers.

Theme 2: There Is Limited Mental Health Knowledge Among Sub-Saharan Africa Immigrants

Theme 2 discusses the lack of knowledge about mental health among immigrants from sub-Saharan Africa as a critical barrier to access to mental health services. Participants (n = 8) indicated limited information about mental health and available services. For example, Participant 2 argued that immigrants generally limit their social circles to their own where there is limited information about mental health. They stated,

> They (immigrants) do not even know that these mental health services exist. There is this aspect of, like they say: ‘the person who picks you up from the airport is a person who directs your life when you get here (United States).’ So, most of the time, they (immigrants) come in and congregate with people they know. These people might not have access to information about mental health services, so they cannot even advise them to get mental health services because they do not know any better anyway. (Participant 2)

In addition, Participant 5 argued about the importance of socialization in gaining new information or perspectives. Similar to Participant 2, they noted that most African

immigrants do not closely interact with native English-speaking Americans where they could gain different perspectives on mental health. They stated,

> The lack of information hinders them (immigrants) from accessing mental health (services). If they do access mental health, this is because they might have been associating with Americans or socializing with Americans to get more information and be more open-minded to access mental health services. Learning from Americans, you see. Whereas not all Africans feel comfortable doing that. So, they tend to be very close-minded. (Participant 5)

The third example came from Participant 7, who also concurred that immigrants of African descent have limited information about mental health. They argued that access to mental health information would help immigrants decide to seek mental health services. They shared the following:

> Lack of information is also one reason we cannot access these (mental health services)—lack of information and ignorance. We do not have the information, and the information is not shared in our community as an immigrant. If anybody has information, they make a better choice because a lack of information enabled us. (Participant 7)

Participant 6 offered divergent views, arguing that more African immigrants were becoming aware of mental health. They stipulated that most female African immigrants were nurses and recently they are venturing into mental health. They argued that this shift was responsible for increased awareness about mental health issues. They stated,

> Many Africans in this country, the women, are primarily nurses. They will pursue professions in health, but mental health, how many did you see? How many nurses did you see that are into mental health issues? But recently the game has changed. So, if you notice that recently we have many nurses who are diversifying into mental health, and not only that, but they are also diversifying into mental health. They are being paid higher than regular nurses in the healthcare field. So as a result, people understand the importance of mental health treatment and the need for that. (Participant 6)

In summary, most participants perceived those immigrants from Africa had limited information about mental health services. They argued that immigrants usually socialize with their own who also have limited mental health information. However, a respondent argued that more information was now available to immigrants, as more female immigrants who are nurses venture into mental health.

Theme 3: Low-Income Levels and Lack of Health Insurance Limit Immigrants' Access to Mental Health Services

Theme 3 discusses that low-income levels and lack of health insurance limit immigrants of African descent from accessing mental health services. Participants noted that mental health services in the United States were expensive and difficult to access without insurance or a decent income. For instance, Participant 2 noted that mental health services were not affordable:

> The main thing is that mental healthcare is costly. I do not know if there is a way of making it cheaper and affordable to everybody because that is a real problem.

> But mental health access, mental health is very expensive. If you do not have a good income and if you do not have insurance, you cannot really access those services.

Participants noted that some immigrants did not have jobs, and those who had jobs were making minimum wage. They also noted that other competing needs, such as taking care of a family, allowed for even less disposable income for health-related concerns. For, example, Participant 1 noted that some immigrants were receiving minimum wage:

> A lot of the immigrants that are coming (to the United States) are receiving a minimum wage. They are on minimum wage income, doing minimum wage jobs, and do not have enough money to purchase private insurance. Most of their employers, those they work for do not provide insurance for them. So, they are not able to access the system; they are not able to get the help they need to help them treat their mental health issues.

Participant 3 argued that the competing needs of immigrants make it difficult to spare money for health care. They also noted that many immigrants lack health insurance. They stated,

> They do not have jobs and even if they have jobs, they have low-paid jobs. So, those that do not are just looking for means to put food on the table for themselves or their small families. So how would they even have the means to go and access the mental healthcare facility? They do not have the means. (Participant 3)

In addition, Participant 7 noted that most immigrants have low skills and, therefore, cannot access high-paying jobs. They concurred that low-income levels make it difficult for immigrants to access mental health services, and their employers do not offer health insurance. They said,

> Some immigrants who come here do not have the skill for high-paying jobs, so most likely, they are paid minimum wage. With that kind of income, more is needed to pay for mental health services that they will receive. They are not making adequate income, and at most of the places they work, employers do not provide health insurance for them. If you are sick, the fees will come out of your pocket. (Participant 7)

Participant 2 argued that immigrants could not afford private insurance due to their low income. They also observed that immigrants are not eligible for free health services in the United States. They argued the following:

> Many people cannot afford it (health insurance) because of the meager wages they earn at their jobs, so they cannot afford it. And because you cannot have a job that allows you to have insurance, that offers your health insurance, you do not have access to (health services). You cannot pay out of your pocket. And because you are an immigrant, and most immigrants do not have a status where they can access free social amenities, they have limited status, so they cannot access free services that are even offered by various counties or communities (Participant 2).

In summary, immigrants may be unemployed or hold low-paying jobs, which limits their access to costly mental health services. Also, employed immigrants are likely

to have employers that do not offer them health insurance. In addition, competing financial needs make it difficult for immigrants to pay for mental health services out of pocket.

Theme 4: Undocumented Immigrants Lack Access to Mental Health Services Due to Fear of Deportation

Theme 4 discusses that undocumented immigrants face multiple barriers to access to mental health services. Participants indicated that the main factor that bars undocumented immigrants from accessing health services is the fear of being deported. For instance, Participant 7 noted that undocumented immigrants lack the requirements to access health services such as proper identification, evidence of income, and health insurance. They stated,

> Now, in some places you go to, you must have your Social Security. You need to have insurance. You need to have a proper ID and so on. You need to have a pay stub showing your source of income or any job insurance showing that you have insurance. Sometimes they want to know their immigrant status. Are you a resident, or are you a citizen? If you are not any of those two, sometimes accessing the system becomes very challenging. The system does not provide services for those who are undocumented in society. (Participant 7)

In addition, participants argued that besides having no income, undocumented immigrants fear that if they access the health system, they will be reported to immigration and deported back home. Such an eventuality would interfere with staying in the United.

States and earning a living. Participant 4 stated the fear of deportation as a barrier to accessing health services in the quote below:

> Then we have the lack of money, a lack of income, no insurance, and they are not working. They are still undocumented, so they always feel that if somebody gets their information, they will be taken back to the immigration office and deported.

However, Participant 6 offered a divergent view, arguing that undocumented immigrants could access health services. They stated that they would be offered services if the undocumented immigrant went to the emergency department of a health facility. They noted that mental health issues such as psychosis and suicidal ideation could not be turned down in the emergency department. They shared the following:

> Yes, if they could go into the emergency department because, in the emergency department, you will not be told that you will not be treated irrespective, especially when you have a psychosis, okay? Or if it gets to the point that somebody wants to kill themself, threatening suicide, you will be treated; you will not be turned down in the emergency department. So, in that way, non-documented immigrants can access health to some level (Participant 6).

In summary, most participants noted that undocumented immigrants faced barriers to accessing mental health services, including unemployment, lack of insurance, and fear of being deported by immigration. Participant 6, however, noted that emergency mental health services could still be offered to undocumented immigrants, such as those with psychosis or suicidal ideation.

Theme 5: Low English Language Proficiency Among Immigrants Limit Access to Mental Health Services

Theme 5 discusses that low English proficiency bars African immigrants from accessing mental health services. Participants noted that some African countries do not use English as an official language, and immigrants from such countries may have difficulties learning and speaking English. In addition, participants argued that even in African countries where English was an official language, the accent was different, which may interfere with communication with health providers who are native English-speaking Americans. Participant 3 summarized the language problem faced by African immigrants by highlighting different languages, accents, and how they affect the ability to interact with native English-speaking Americans:

> First, for people (who) come from Africa, their first language is not English. And even some who learn English learn it as a second language, and they do not have an accent here in America. Some of the English that (they) were taught in Africa is mostly British English. So, when they come here, there is a problem with the accent. Some speak French; their first language was French, not even English or a second language. And because sometimes you get to a place, and you are expressing yourself, and somebody keeps asking you. “What do you mean?” Or “What are you saying? Oh, I do not understand what you are saying.” It frustrates the immigrant, and they will not even want to expose themselves. He is ashamed because he cannot express himself in the accepted language.

Participant 5 reported their language struggles after relocating from Cameroon to the United States. They noted that they had to learn a new language, and others struggled to understand them. They stated,

> And then another reason is the language barrier. For instance, I came from Cameroon. When I came here, I struggled a lot with speaking English, so every time I had to speak, I had to repeat myself almost three to five times before someone could understand what I was trying to say. (Participant 5)

Participant 8 indicated that the different English dialects between immigrants and native English-speaking Americans may hinder communication. They argued that an immigrant might find it challenging to explain their mental health issues and be understood by the health provider. They shared,

> Even when we (African immigrants) speak English, it might be a little different and a little off because it is something we have learned. But then we learn it to communicate with the rest of the world, like here in America; they speak English as their primary language. So, it could be a big barrier. This client or somebody with mental health issues cannot come out to explain what they are going through and how they feel because they cannot express themselves (in English). (Participant 8)

On the other hand, some divergent views were offered regarding the language barrier hindering access to health services. For example, Participant 2 argued that health facilities have translators who can mediate conversations between patients and health providers. They stated, “Language could be a problem, but I do not think it is a big

problem because when you go to most of those facilities, you have the opportunity for people for translation and interpretation." However, Participant 6 noted that language interpreters are only sometimes available, and when available, some also need help understanding patients. They noted that, in such cases, language barriers may affect treatment. They said,

> So, during treatment, some people use an interpreter, and in the hospital, they use an interpreter. And there are also issues with interpreters, especially when they do not understand exactly what the patient is saying. So, that can hinder or affect the patient's treatment because what was interpreted is not what was said by the patient. Wrong interpretation and most treatment facilities for mental health, most mental health providers do not have interpreters. Those who are doing private providers, let me use it that way, they do not have interpreters. And several patients are seeking treatment in programs that can understand their language, so sometimes it is difficult to find such programs. (Participant 6)

In summary, the language barrier was reported as a hindrance among African immigrants whose first language is not English or who have different English dialects than native English-speaking Americans. Divergent views indicated that some health facilities had language interpreters who may mediate communications between patients and health providers. However, it was pointed out that not all health facilities provide access to language interpreters.

Summary

This qualitative study aimed to explore the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore. A research question was identified to achieve the study purpose: What are the experiences of sub-Saharan African immigrants accessing mental health services in Baltimore? Five data themes were uncovered from data analysis to address the research question. The first theme discussed the stereotyped beliefs that hinder immigrants of African descent from seeking mental health services. The stereotypes linked mental health problems to madness, and madness was linked to curses which could not be addressed with modern medicine. The fear of madness explains the silence and stigma that African immigrants who suffer from mental health problems face. Further, the beliefs about mental health problems led immigrants to seek help from religious leaders and traditional healers.

The second theme discussed the lack of knowledge about mental health as a critical barrier to mental health services access among African immigrants. Participants perceived that immigrant from Africa had limited information about mental health services. They argued that immigrants usually socialize with their own who also have limited mental health information. However, a divergent view offered that many female African immigrants were nurses and had ventured into mental health.

The third theme discussed that low-income levels and lack of health insurance among immigrants of African descent limited their access to mental health services. Participants argued that African immigrants might be unemployed or hold low-paying jobs, which limits their access to costly mental health services. Also, employed

immigrants were likely to have employers that did not offer them health insurance. In addition, competing financial needs made it difficult for immigrants to pay for mental health services out of pocket.

The fourth theme discussed that undocumented immigrants face multiple barriers to access to mental health services, including unemployment, lack of insurance, and fear of being deported by immigration. In one divergent view, a participant noted that emergency mental health services could still be offered to undocumented immigrants. These conditions included those with psychosis or suicidal ideation.

The fifth theme was that low proficiency in English bars African immigrants from accessing mental health services. Respondents noted that African immigrants whose first language was not English or who had different English dialects than native English-speaking Americans faced communication barriers. Divergent views indicated that some health facilities had language interpreters who may mediate communications between patients and health providers. However, it was pointed out that not all health facilities provided access to language interpreters. In Chapter 5, I present an interpretation of the findings, the limitations of the study, and recommendations for future research. I conclude the chapter with a section on the implications of this study for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The data analysis process using Braun and Clarke's (2006) six-step thematic analysis revealed five themes: (a) stereotyped beliefs about mental health contribute to poor health-seeking behaviors among immigrants from sub-Saharan Africa, (b) there is limited mental health knowledge among sub-Saharan Africa immigrants, (c) low-income levels and lack of health insurance limit immigrants' access to mental health services, (d) undocumented immigrants lack access to mental health services due to fear of deportation, and (e) low English language proficiency among immigrants limit access to mental health services. In this chapter, I present my interpretation of the findings, conclusions as well as implication for social change and recommendations for future research.

Interpretation of the Findings

The principle finding of Theme 1 was that stereotypes about mental health exist among people of African descent. These stereotypes, according to most of the respondents, link mental health problems to madness, which is linked to curses that cannot be addressed with modern medicine. The fear of madness explains the silence and stigma that those who suffer from mental health problems face. Further, the beliefs about mental health problems shape help-seeking from religious leaders and traditional healers. The implication of these findings is that it is challenging for those in Africa to access appropriate medical support services that can assist them given their affiliation with various cultural norms that negatively portray mental health issues. These findings are synonymous with the findings of Choudhry et al. (2019), who conducted a meta-analysis

to examine beliefs and perceptions about mental health issues. According to the researchers, in Africa, discussing issues related to mental health is generally taboo. When one member of a family falls ill, the rest of the members believe they are cursed as well. However, psychological issues are increasingly prevalent and cannot be disregarded. Multiple societal shifts over the previous half-century have led to this trend (Choudhry et al., 2019). Rössler (2019), in another qualitative study on the stigma of mental disorders, also concurred with the findings of Choudhry et al. (2019). According to Rössler, the majority of Africans attribute mental illness to someone else's interference in one's life. People with mental illness are sometimes misunderstood as being bewitched or under a spell. Some people's mental illness is likened to possession by evil spirits. Even if one disagrees, they cannot dispute that a person's mental health can be negatively impacted by factors outside of themselves. These findings underpin the fact that seeking psychological help in Africa is a challenge because of the negative communal stereotypes that surround mental health issues.

The overarching finding of Theme 2 was that most sub-Saharan African immigrants in Baltimore perceived those immigrants from Africa had limited information about mental health services. The participants argued that immigrants usually socialize with their own who also have limited mental health information. Participant 2, for instance, indicated that, "[immigrants] do not even know that these mental health services exist." The implication of this finding is synonymous with those of the findings of Theme 1, in the sense that access to mental health services by Africans is limited by various limitations which, specifically in the case of this theme, is limited information regarding

this health challenge. These findings align with those of Boukpessi et al. (2021), who conducted a qualitative study to analyze willingness to use mental health services for depression among African immigrants and white Canadian-born people in the province of Quebec, Canada. According to Boukpessi et al., just as one needs information and know-how to navigate the insurance system, one needs information on a wide variety of healthcare institutions, rules, and practices in order to properly utilize services. Immigrant populations often do not have these skills or information and thus remain ostracized from the healthcare system. In another study, Chao et al. (2019) supported the perspectives of Boukpessi et al., by stating that without regular contact with healthcare professionals, individuals may not receive necessary and regular check-ups, which are critical in identifying illness before it becomes severe. Access to information on mental health is thus a critical challenge that Africans face, and this circumstance calls for the implementation of effective public communication channels to ensure every African, despite their location, economic, or social status, receives sufficient information on mental health issues.

The overarching finding of Theme 3, on the other hand, was that immigrants may be unemployed or hold low-paying jobs, which limits their access to costly mental health services. Also, employed immigrants are likely to have employers that do not offer them health insurance. In addition, competing financial needs make it difficult for immigrants to pay for mental health services out of pocket. The implication of this finding is that financial constraints or economic capacity of immigrants limits equitable access to mental health services amongst them. These findings are aligned to those of Brow et al.

(2020), who conducted a systematic literature review to examine perceptions of mental health and perceived barriers to mental health help-seeking behaviors amongst refugees. According to Brow et al., financial barriers to healthcare are perhaps the most obvious and well documented hurdles in accessing treatment. Immigrant populations are often at the low end of the socioeconomic spectrum and struggle to meet the financial obligations of everyday life. Financial barriers were particularly high among African immigrants who, despite being more educated than the average immigrant, often do not have adequate financial resources (Brow et al., 2020). Adekeye et al. (2018), in another related study meant to examine barriers to healthcare among African immigrants in Georgia, supported those findings. Adekeye et al. found that concerns around cost dissuaded nearly half of the surveyed African immigrants to access care. In addition to low incomes, immigrants tend to be underinsured, thus imposing further financial costs of care. This is due to several factors. First, immigrants are often employed in temporary or irregular work, paid under the table, or are in a field that does not offer health care benefits, depriving them of access (Adekeye et al., 2018). Second, immigrants who are in the country illegally fear reprisal if they are caught using public healthcare, causing them to avoid contact with healthcare services whenever possible (Adekeye et al., 2018). Immigrants, therefore, struggle to navigate the complicated bureaucratic healthcare institutions with limited financial or linguistic resources at their disposal.

An analysis of data related to Theme 4 revealed that most participants noted that undocumented immigrants faced barriers to accessing mental health services, including unemployment, lack of insurance, and fear of being deported by immigration. A

divergent view indicated that emergency mental health services could still be offered to undocumented immigrants in the cases of psychosis or suicidal ideation. The implication of this finding is that, apart from financial constraints, immigrants also face other barriers to accessing mental health services, such as fear of deportation or lack of medical insurance, particularly if they are undocumented. These findings support the findings of Olukotun et al. (2019), who conducted a qualitative study to explore the lived experience and coping strategies of undocumented African migrant women. Olukotun et al. recorded the unique experiences and stressors to immigrant women living as undocumented workers. According to the researchers, African immigrant women in France perceived higher degrees of discrimination and displayed more avoidant behavior to the health system. These gendered differences, while sometimes physiological, are often dictated by culture. Though non documentation of immigrants is not a primary determining factor, its predispositions shift macro trends in mental healthcare resource utilization (Olukotun et al., 2019). Cha et al. (2019) similarly agreed that non documentation of immigrants can significantly affect their access to mental healthcare resources. According to Cha et al., whether or not a patient maintains care over a longer period depends on their perception of the efficacy of care. A patient who is happy with their medical professional and sees improvement in symptoms will likely continue to attend, while those who do not see improvement or are uncomfortable with the process might stop going prematurely. Others display a general mistrust of governmental organizations, especially those who are undocumented or are otherwise in tension with institutions (Cha et al., 2019). In terms of achieving equitable access to mental healthcare services for all people regardless of social

constructs, non-documentation of immigrants, unemployment, fear of deportation, and lack of medical coverage, these are important aspects to consider.

Finally, an analysis of Theme 5 data revealed that the language barrier was reported as a hindrance among African immigrants whose first language is not English or who have different English dialects than native English-speaking Americans. Divergent views indicated that some health facilities had language interpreters who may mediate communications between patients and health providers. However, it was pointed out that not all health facilities provide access to language interpreters. The implication of these findings is that native English-speaking Americans are more privileged than other ethnic groups when it comes to access to mental healthcare services. These findings are supported by the findings of Ahad et al. (2019), who conducted a qualitative study to assess the likelihood of having a regular health care provider among African American and African immigrant women. According to Ahad et al., immigrant populations face diverse challenges after arrival in their host nation. Lack of language skills and acculturation are primary and significant initial hurdles new arrivals must navigate in order to acculturate and adequately access services and institutions (Ahad et al., 2019). Immigrants also sacrifice significant social capital in their transition to a new nation, leaving behind personal networks and extended families in their country of origin. Kamrul et al. (2021), in another study, added that these stressors often manifest as more serious mental health issues, causing both psychological and physical symptoms. Therefore, although there may be healthcare programs that cater to both the general

population and immigrants specifically, divergent levels of healthcare utilization among varying ethnic groups remains a barrier for equitable health outcomes.

Conclusions

The purpose of this qualitative study was to explore the experiences of sub-Saharan African immigrants in accessing mental health services in Baltimore. To achieve the objective of this study, which was to explore the experiences of sub-Saharan African immigrants accessing mental health services in Baltimore, I used semistructured, one-on-one in-depth interviews with eight sub-Saharan African immigrants in Baltimore. Following my analysis of each theme, noted through Braun and Clarke's (2006) six-step thematic analysis, five main findings were established, with the first one being that stereotypes about mental health exist among people of African descent (Theme 1). These stereotypes, according to most of the respondents, link mental health problems to madness, which is linked to curses that cannot be addressed with modern medicine. The fear of madness explains the silence and stigma faced by those who suffer from mental health problems. Further, the beliefs about mental health problems shape help-seeking behaviors from religious leaders and traditional healers. I also learned that most sub-Saharan African immigrants in Baltimore perceived those immigrants from Africa had limited information about mental health services (Theme 2). They argued that immigrants usually socialize with their own who also have limited mental health information.

The analysis also revealed that immigrants may be unemployed or hold low-paying jobs, which limits their access to costly mental health services (Theme 3). Also, employed immigrants are likely to have employers that do not offer them health

insurance. In addition, competing financial needs make it difficult for immigrants to pay for mental health services out of pocket. An analysis of data related to Theme 4 revealed that most participants noted that undocumented immigrants faced barriers to accessing mental health services, including unemployment, lack of insurance, and fear of being deported by immigration. A divergent view indicated that emergency mental health services could still be offered to undocumented immigrants, such as those with psychosis or suicidal ideation. Finally, Theme 5 revealed that the language barrier was reported as a hindrance among African immigrants whose first language is not English or who have different English dialects than native English-speaking Americans. Divergent views indicated that some health facilities had language interpreters who may mediate communications between patients and health providers. However, it was pointed out that not all health facilities provide access to language interpreters.

Implications for Social Change

This study will contribute to the gap in knowledge about sub-Saharan African immigrants' use and access to mental health services. In addition, it has provided an opportunity for sub-Saharan African immigrants who have suffered from mental health and sought help to tell their story. Also, the findings from this study may benefit positive social change through improving the mental health outcomes and service utilization among sub-Saharan African immigrant populations. Such a change is attainable by providing sub–Saharan African immigrants with mental health information to override the stereotyped beliefs. According to Fanfan and Stacciaraini (2020), provision of mental health information is fundamental in breaking stereotypes that hinder individuals from

certain communities from seeking medical help. As such, findings relating the low levels of mental health services utilization to the stereotype beliefs will play a critical role in designing social work interventions to help enhance the social well-being and mental health of African immigrants in the United States.

The study also holds social significance because it links the experiences of Sub-Saharan Africans Immigrants in accessing mental health services to barriers such as fear of being deported by immigration, and especially among undocumented members of the population. Particularly, findings obtained in this study revealed that members of the population hold the belief that their peers and family members will not be provided with emergency mental health services because of being undocumented. Further, self-stigma and public stigma have been found typical and deter respondents' help-seeking among sub-Saharan African immigrants (McCann et al., 2017) However, this is not the case since Escamilla and Sassa (2020) indicated that even undocumented immigrants receive emergency medical services despite their undocumented status. Therefore, such findings can be used to design social work interventions that provide accurate information leading to improved mental well-being among members of the community.

The study findings also point towards low proficiency in English as another chief factor that hinders Sub-Saharan African Immigrants from accessing mental health services. Such study findings will prove useful in enhancing the mental wellbeing of members of the population through elimination of the communication barrier. As indicated by (Haffizulla et al. (2020), African immigrants that are not proficient in English often lack sufficient access to medical services, and especially in cases where

language interpreters are unavailable or incompetent. Therefore, such findings will help improve the mental wellbeing of the sub-Saharan African Immigrants community by ensuring that health facilities are equipped with language interpreters to mediate communications between patients and health providers.

Practitioners in Baltimore may use findings of this study to improve use and access to mental health services among immigrants from sub-Saharan Africa. Findings from this study may be used to improve policy and practice on mental health immigrant access and use.

Recommendations

To be able to overcome stereotype challenges related to the delivery of mental health services, Aronson et al. (2019) suggested the following approaches: stereotype replacement, counter-stereotypic imaging, individuation, perspective taking, and partnership building. It is important to recognize that a response is based on a stereotype and consciously adjust the response. Additionally, one can counter-image the individual as the opposite of the stereotype. Moreover, seeing the person as an individual rather than a stereotype (e.g., learning about their personal history and the context that brought them to the doctor's office or health center) is another strategy for fighting stereotypes (Akinsulure-Smith, 2017; Aronson et al., 2019). To increase opportunities for contact with individuals from different groups. Aronson et al. (2019) also suggested expanding one's network of friends and colleagues or attending events where people of other racial and ethnic groups, gender identities, sexual orientation, and other groups may be present

and reframing the interaction with the patient as one between collaborating equals, rather than between a high-status person and a low-status person.

With regards to limited access to information on mental health issues, Hendrie et al. (2020) suggested the establishment of free online platforms with information on mental issues. Given the increasing number of smartphone users globally, including in the rural regions, this approach is both sustainable and feasible (Hendrie et al., 2020; Oshima et al., 2021). According to Hendrie et al. (2020), the public's awareness of health issues has increased due in large part to websites like NHS Choices, which can help individuals choose whether they need medical attention and, therefore, relieve some of the strain on health care systems.

Concerning financial constraints or economic capacity of immigrants limiting their equitable access to mental health services, Chisholm et al. (2019) suggested that countries all over the world, not just the United States, should consider securing new funding from external or domestic sources, and more efficient and suitably targeted use of existing resource allocations can also markedly increase the flow of funds towards the psychological health system goals of augmented service coverage and financial protection. Other suggestions include higher use of existing budgets via improved planning, improved integration of psychological health into primary care guidelines and practice, capacity building or public–private partnerships, and introduction or exploration of performance or results-based financing measures, such as through pay incentives in primary care (Evans, 2018).

To ensure that even undocumented immigrants access mental health services equitably, Beck et al. (2019) suggested a more inclusive approach in how they are handled. As many federal measures generate unfounded panic and hurt illegal individuals, states have an opportunity to do better. State leaders can create a better educated workforce, guarantee that more employees are paid fairly, and earn more revenue to help pay for schools and other public services that, together, provide a solid foundation for broadly shared prosperity if they adopt a pragmatic, humanitarian approach (Beck et al., 2019).

Finally, proper acculturation processes are necessary to ensure that immigrants are able to adapt to the culture and language of the locals easily and quickly. This approach would provide them a fair chance at accessing and utilizing mental health services without experiencing any type of language barrier. Alaazi et al. (2018) stated that immigrants even have the advantage of acculturation and language acquisition, both of which aid in lowering anxiety. Through school and sports, they tend to be better integrated into public institutions than their parents and gain a greater insight into the national culture (Alaazi et al., 2018). Multigenerational studies have demonstrated a significant decrease in anxiety and stress among subsequent generations of immigrants (Lee, 2019).

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Appendix: Interview Guide

Experiences of Sub-Saharan African immigrants on mental health care access

Hello Participant,

I thank you for agreeing to participate in my study. You have reviewed the consent Form and provided informed consent. I really appreciate you for providing that. Please know that you can stop this interview at any time or ask to skip and not answer any question that you prefer not to answer.

As you know, my study is focused on the experiences of Sub-Saharan African immigrants and their access to mental health care. I am going to ask you questions on access to mental health access. Please provide your opinion on experiences for each item believed to influence your access to mental health services.

Do you have any questions or concerns about this study, consent, or the overall process?

Ok, I will begin with my questions:

1. What is your general opinion and feeling toward mental health access among immigrants of African descent in the United States?

a. For instance, is it easy to access mental health services? Is there stigma? What factors went into your opinion here?

2. What is your opinion on the utilization of mental health services by African immigrants?

b. Do immigrants tend to seek mental health support? Why or why not?

3. Why do you think there is a low access rate to mental health services among African immigrants?

4. What is your experience of the barriers to mental health care access by African immigrants?

5. What are your views on mental health access by undocumented African immigrants?

a. For instance, are they able to access mental health care? Why or why not?

6. What is your view on the connection between health insurance and access to mental health among African immigrants?

7. Financial limitations are key barrier to mental health access by African immigrants. How do you see or experience financial limitation as affecting access to mental health care?

8. In your experience, how do cultural norms influence access to mental health seeking behavior among African immigrants? Why or why not?

9. Do you think beliefs and norms about mental health influence mental health seeking behavior among African immigrants? Why or why not?

10. How do you think language barriers influence access to mental care by African immigrants?

11. Do you think there is distrust in formal providers contributed to low rate of health care access among African immigrants? Why or why not, and do you think this affects use of mental health services?

12. How do you think an availability or preference for alternative health services influences access or use of formal mental health by African immigrants?

13. Do you think there is lack of information about treatment options influence access to mental health care among immigrants? Why or why not?

14. What is your opinion of the quality of mental health care experienced by African immigrants? Can you provide an example or situation to explain this opinion?

15. Is there anything else you would like to add?

Thank you so much for participating in this study. I may contact you for a follow up at some point. Please feel free to email or call me with any questions about this study.

Again, thank you.

Appendix B: CONSENT FORM

You are invited to take part in a research study about Sub- Saharan African Immigrants Experiences in Utilizing Mental Health Services in Baltimore. This form is part of a process called “informed consent” to allow you to understand this study before deciding whether to take part.

This study seeks 8-12 volunteers who are:

- who are Sub-Saharan African Immigrants living in Baltimore?
- who have experienced mental health conditions and barriers and have sought relevant healthcare services?

This study is being conducted by a researcher named _Helen Tanwani who is a student at Walden University.

Study Purpose:

The purpose of this qualitative study is to explore the experiences of Sub-Saharan African immigrants in accessing mental health services in Baltimore.

Procedures:

This study will involve you completing the following steps:

Sign a consent form consenting to participate voluntarily in the study.

- Take part in a 1hour 30 minutes confidential audio recorded interview with the researcher either by (Telephone or Zoom meeting).
- After the interview, the researcher will email you a transcript of your interview to review and make corrections if needed. This will take 15-20 minutes.
- After transcribing the interviews, the researcher will contact you in a 20–30-minute phone call to share the interpretation and hear your feedback.

Here are some sample questions:

1. What is your general opinion and feeling toward mental health access among immigrants of African descent in the United States?
    a. For instance, is it easy to access mental health services? Is there stigma? What factors went into your opinion here?

2. What is your opinion on the utilization of mental health services by African immigrants?
    b. Do immigrants tend to seek mental health support? Why or why not?
3. Why do you think there is a low access rate to mental health services among African immigrants?

Voluntary Nature of the Study:

Research should only be done with those who freely volunteer. So, everyone involved will respect your decision to join or not.

If you decide to join the study now, you can still change your mind later. You may stop at any time. and without giving a reason. If you withdraw from the study before data collection is completed, your data will be returned to you or destroyed.

Risks and Benefits of Being in the Study:

Being in this study could involve some risk of the minor discomforts that can be encountered in daily life such as sharing sensitive information, or confidential information about yourself by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question or take part in the interview if you feel the questions(s) are too personal or if talking about them makes you uncomfortable. Should you need counseling help, call Baltimore free 24-hour counseling hotline at: 410 433 5175. With the protections in place, this study would pose minimal risk to your wellbeing.

This study offers no direct benefits to individual volunteers. The aim of this study is to benefit society by improving policy and practice on mental health immigrant access and use. Also, by improving the mental health outcomes and service utilization among sub-Saharan African immigrant populations. Once the analysis is complete, the researcher will share the overall results by providing a summary of the results to all participants through telephone call or email.

Payment:

Your participation in this study is free. No payment will be made for participating in this study.

Privacy:

The researcher is required to protect your privacy. Your identity will be kept confidentiality within the limits of the law. The researcher will assign code names/numbers for participants that will be use on all research notes and documents. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers so this would not involve another round of obtaining informed consent. Data will be kept secure by_ keeping notes, interview transcriptions, and any other identifying participant information in a locked file cabinet in the personal possession of the researcher. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You can ask questions of the researcher by phone at: 443 851 3082 or by email: helen.tanwani@waldenu.edu. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at 612-312-1210. Walden University's approval number for this study is 06-30-22-0079283. It expires on June 29, 2023.

You might wish to retain this consent form for your records. You may ask the researcher or Walden University for a copy at any time using the contact info above.

Obtaining Your Consent

If you feel you understand the study and wish to volunteer, please indicate your consent by completing and signing this form.

_____	_____
Printed Name of Participant	Date
_____	_____
Participant Signature	Date
_____	_____
Researcher's Signature	Date

Appendix C: RESEARCH FLYER

My name is Helen Tanwani. I am a student at Walden University pursuing a PhD in Human and Social Services. The title of my Dissertation is: **Sub-Saharan African Immigrants Experiences in Utilizing Mental Health Services in Baltimore.** To complete this study I will like to interview 8- 12 voluntary Sub-Saharan African Immigrants, **18years and above**, living in Baltimore who have experienced mental health conditions and barriers and have sought relevant healthcare services.

If you fall in this category and interested in participating in this study, please contact me at: **443 851 3082** or email me at: **helen.tanwani@waldenu.edu.**

Thank you for your participation.