WEST AFRICAN IMMIGRANTS IN NORTHERN CALIFORNIA AND THEIR ATTITUDES TOWARD SEEKING MENTAL HEALTH SERVICES

Florence Igboama Nwokocha  
B.A., San Jose State University, 2000  
M.A., California State University, Sacramento, 2005

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WEST AFRICAN IMMIGRANTS IN NORTHERN CALIFORNIA AND THEIR ATTITUDES TOWARD SEEKING MENTAL HEALTH SERVICES

A Project

by

Florence Igboama Nwokocha

Approved by:

__________________________________, Committee Chair
Jude M. Antonyappan, Ph.D.

Date: ____________________________
Student: Florence Igboama Nwokocha

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______________________________, Graduate Coordinator
Teiahsha Bankhead, Ph.D., L.C.S.W.  ______________________

Date

Division of Social Work
Abstract

of

WEST AFRICAN IMMIGRANTS IN NORTHERN CALIFORNIA AND THEIR ATTITUDES TOWARD SEEKING MENTAL HEALTH SERVICES

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Florence Igboama Nwokocha

This quantitative study investigated the attitudes toward seeking psychological help as predicted by degree of acculturation, severity of self-reported problems, and beliefs about the cause of mental health problems among West African immigrants in Northern California. The research questions explored were centered on the level of comfort in admitting they have mental, emotional and behavioral problems, and the level of comfort in seeking mental health services from qualified professionals in Northern California. The study also explored education, economy, acculturation, and access to information influencing the immigrants’ attitudes towards seeking mental health services. One hundred and 16 respondents participated in the survey. The results identified interactional attribution beliefs about mental health problems as the only significant predictor. West African immigrants reported various concerns with their mental and physical health. Overall, they reported preference for the use of informal systems of support to resolve their emotional concerns and the use of medical doctors for physical concern. In particular, West African immigrants’ preferred to seek the help of family, elder in the
community, spiritual healer and using herbal means to solve their mental health needs than going to medical doctors in the western system of medicine.

__________________________________, Committee Chair
Jude M. Antonyappan, Ph.D.

Date: ____________________________
DEDICATION

First of all, I want to dedicate this research to God, and to Jesus Christ, my guiding light, and the only one who provided me with a clear vision along my personal, professional, and academic paths. God, You have done it again, and again. In many ways You have showed me that You are truly the God of endless possibilities.

Lord, you have been the torch that directs my path. You have always helped me when I needed it the most. Therefore, I give all Glory to Jesus Christ and to you my God.

To my late son, Chinemeze Azuonye Nwokocha, whose life circumstances inspire me in my chosen profession. Son, it has been three years since you left us. But no moment passes that I do not think of you; your smile, how you look at my face and know when I am sad, how you inquire if I am okay, and how you notice my hair when it is colored. Son, even though your journey on this earth was cut short due to your health, I miss you so much. I will always love you.

With my deepest love and appreciation to my soul mate, best friend, and husband, Syringa O.C. Nwokocha, for his patience, love, encouragement, and tolerance during some of the most tempestuous and frustrating times during the completion of my research.

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Dedication</strong></td>
<td>vi</td>
</tr>
<tr>
<td></td>
<td><strong>Acknowledgments</strong></td>
<td>viii</td>
</tr>
<tr>
<td></td>
<td><strong>List of Tables</strong></td>
<td>xiv</td>
</tr>
<tr>
<td></td>
<td><strong>List of Figures</strong></td>
<td>xvi</td>
</tr>
<tr>
<td></td>
<td><strong>Chapter</strong></td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>The African Concept of Mental Health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Statement of Problem</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Purpose of the Study</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Significance of the Study</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Theoretical Frameworks</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Study Questions</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Definition of Terms</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Limitations</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Assumptions</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Conclusions</td>
<td>26</td>
</tr>
<tr>
<td>2. REVIEW OF LITERATURE</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Immigrants’ Attitudes Towards Mental Health</td>
<td>29</td>
</tr>
</tbody>
</table>
Group-level Acculturation ........................................................................32
African Immigration to the U.S. .................................................................33
African Immigrants and Mental Health Issues .........................................36
West African Immigration to U.S. ............................................................37
West African Immigrants’ Perceptions of Mental Health .........................38
West African Cultural Beliefs .................................................................47
The Communication Barriers to Accessing Mental Health Services by
West African Immigrants .........................................................................50
Role of Religion .........................................................................................53
Belief in West African Traditional Medicine ............................................57
Stigma and Shame About Mental Illness ..................................................61

3. METHODOLOGY ................................................................................67

Study Questions .......................................................................................67
Research Design .......................................................................................68
Sampling ...................................................................................................68
Participants ...............................................................................................69
Instruments ...............................................................................................70
Procedure ..................................................................................................71
Data Collection .........................................................................................72
Protection of Human Subjects ...................................................................73
Explanation of Implied Consent ...............................................................74

4. ANALYSIS OF DATA .........................................................................76
LIST OF TABLES

1. Table 1. Demographic Profile of the Respondents ..................................................78
2. Table 2. Cross tabulation of the Contact that respondents will make to address their health concerns with Gender ............................................................................80
3. Table 3. Total Household Income and English Language Proficiency Cross Tabulation ..........................................................................................................................83
4. Table 4. Country of Origin of the Respondents ..........................................................84
5. Table 5. Higher Education level and confidence in finding relief in psychotherapy when experiencing emotional crisis .................................................................85
6. Table 6. Cross tabulation of respondents education level and their attitudes of being ashamed of mental illness ...................................................................................86
7. Table 7. Lack of faith in clinic’s ability to solve personal problems .........................88
8. Table 8. Attitude on whether to recommend that a friend see a counselor ...............88
9. Table 9. Feel Uneasy Going to see a Counselor ............................................................89
10. Table 10. Respondents’ Perception of Strength of Character and Overcoming Mental Conflict Without Assistance .................................................................90
11. Table 11. Respondents’ Perceptions of Receptivity to Professional Advice when Feeling Lost ..................................................................................................................91
12. Table 12. Willingness to get psychological help ........................................................92
13. Table 13. Attitude on discussing problems with immediate family .......................93
14. Table 14. Attitude on Being Secure in Good Inpatient Psychiatric Unit ...............94
15. Table 15. Attitude on Being Secure in Good Inpatient Counseling Unit ............95
16. Table 16. Belief in Seeking Professional Help When Having a Mental Breakdown ..........................................................................................................................96
17. Table 17. Attitude on Having Friends as Advisors Rather than a Psychologist.................................................................97
18. Table 18. Attitude on Resenting a Person who wants to know about my Personal Difficulties .........................................................98
19. Table 19. Respondents’ Attitude of being Ashamed of Mental Illness .............99
20. Table 20. Attitude on Knowing Everything about Oneself ..............................100
21. Table 21. Willingness to get Psychological Help if Worried or Upset for a Long Time ..........................................................101
22. Table 22. Confidence in Finding Relief in Psychotherapy when Experiencing an Emotional Crisis .................................102
# LIST OF FIGURES

<table>
<thead>
<tr>
<th></th>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Figure 1. The body mind psychopathology link</td>
<td>43</td>
</tr>
<tr>
<td>2</td>
<td>Figure 2. Framework for acculturation research</td>
<td>44</td>
</tr>
<tr>
<td>3</td>
<td>Figure 3. Berry’s model of acculturation</td>
<td>46</td>
</tr>
<tr>
<td>4</td>
<td>Figure 4. Gender distribution of the respondents</td>
<td>77</td>
</tr>
<tr>
<td>5</td>
<td>Figure 5. Demographics city of respondents</td>
<td>79</td>
</tr>
<tr>
<td>6</td>
<td>Figure 6. The cross tabulation respondents’ household income and higher education level</td>
<td>81</td>
</tr>
</tbody>
</table>
Chapter 1

INTRODUCTION

The United States of America is a diverse nation of immigrants from almost all the nations of the world, enriched with the cultural influences of the many immigrant families that have settled here. Among these immigrant families are Africans who have come to the U.S. for diverse reasons. These reasons may include, but are not limited to, seeking higher education, escaping political conditions and social unrest in their countries of origin, a desire for economic stability, or simply for mere adventure (Ndubike, 2002; Okafor, 2009). The struggles that people have been willing to undergo throughout history in coming to the United States are recognized in many disciplines. People are willing to risk everything that they have, and often even their lives, in the process of obtaining the American dream for themselves, their families and their descendants. West African immigrants also undergo this same struggle in pursuit of the American dream. Nevertheless, once they enter the United States they realize that the assimilation and acculturation processes are not as easy as they had hoped. With this complication, many members of the West African immigrant community in the US struggle for many years to rebuild their lives. West African immigrants face a number of problems as they attempt to settle in the U.S. Immigration itself is a stressor, and may significantly contribute to adjustment problems (Darman, Getachew, Jabreel, Menon, Okawa, & Teklamarian, 2001).
The United States of America (USA), being a nation of immigrants, has never had a homogeneous population in terms of culture, race, or ethnicity (Darman et al., 2001). Racial/ethnic minorities in the USA have reached critical mass, and their numbers are expected to continue increasing. For instance, from 1980 to 1990 the non-White population grew at a phenomenal rate (African-American 13%; Native-American, 37%; Hispanic/Latino, 53%; Asian-American/Pacific Islanders, 17%) compared to the white population (6%) (Sue & Sue, 2004). It is, therefore, projected that by the year 2050 minorities in this country will constitute a numerical majority (Betancourt, Green, & Carillo, 2000; Kollehlon, & Eula, 2003; Sue, Sue, & Sue, 1997; US Census Bureau, 2000).

The influx of immigrants to the United States from 1990 to 2000 made it necessary for the American social service and mental health systems to generate new services, appropriate sensitivities, and interventions for the nation’s newest immigrants (Foster, 2001). As a result, psychologists and other clinicians are now challenged to explore ways to best serve the needs of the increasing numbers of immigrants social and mental health services. Cultural competency begins with an understanding of cultural variations between and among different racial and ethnic populations, including rules for behavior, language, religion, history, traditional beliefs and values, language proficiency, and reasons for immigration (Cross et al., 1989). The cultural understanding, meanings, and symbols that immigrants bring with them from their home countries are critical in understanding immigrant family life (Foner, 1997).
Because of the increasing racial and ethnic diversification of the USA, most counselors and psychiatrists can expect to see clients from diverse racial and ethnic backgrounds. While national interest in the mental health of ethnic minorities has increased in the past decade, the human service professions have historically failed to meet the particular mental health needs of various underserved ethnic groups (Baruth & Manning, 2003). Several studies continue to reveal that American Indians, Asian Americans, African Americans, and Hispanic Americans tend to underutilize traditional outpatient mental health services, such as counseling and family therapy (Chung & Snowden, 1990; Leong, 1994). Culturally diverse clients are less likely to seek out counseling services, and, when they do, are more likely to be given more serious diagnoses than their ethnic majority counterparts from the dominant culture (Doung-Ohtsuka & Ohtsuka, 2001). For some, describing symptoms in somatic ways is not seen as a problem, and as a result, not all their symptoms are being treated. Ethnic minority clients tend to terminate counseling at the rate of more than 50% after only one contact with a therapist. This is in marked contrast to the less than 30% termination rate among White clients (Sue & Sue, 1997). Often, Ethnic minority clients feel that a stranger is unable to help them, so they are more inclined to seek help from family members or someone in their own community.

In addition to increases in the number of African Americans, Asian Americans, and Hispanic Americans in the USA, there has also been an increase in the number of African subgroups, specifically West Africans, since the 1980s (Okafor, 2009; Thomas,
Limited attention has been given to the African born population in the psychological literature, despite the fact that an increasing number of Black people in the U.S. are immigrants from African countries (Johnson, Farrell, & Guinn, 1997; Larsen, 2004). West African immigrants are the subject of this research study for two reasons: First, this population represents the largest proportion of African immigrant populations within the U.S. (Dixon, 2006); and second, West African immigrants have been less studied compared to other African immigrant populations (Bagley, 1971; Kidd, 1965; Littlewood & Lipsedge, 1981; Nwadiora, 1996; Rwegellera, 1977). Research is needed to better understand West African immigrants’ concept of mental health and their attitudes towards seeking traditional Western care. Culturally competent psychologists and other practitioners must gain an understanding of the relevant mental health issues of West African immigrants to meet their mental health needs. Generally, West African immigrants do not admit to serious psychological problems, and problems with mental illness are usually kept at home (Darman et al., 2001).

The African Concept of Mental Health

Africa is a continent that is culturally diversified. Although there are cross-cultural and ethnic differences amongst the people of Africa, there is nonetheless a general belief among Africans that both physical and mental diseases originate from various external causes such as a breach of a taboo or custom, disturbances in social relations, hostile ancestral spirits, spirit possession, demonic possession, evil machination, evil eye, sorcery, natural causes, and affliction by God or gods (Betancourt
et al., 2000; Gaines, 1998; Idemudia, 2004; Okafor, 2009; Thomas, 2008). According to Taussing (1980), the most important thing about society is the relationship between people, and as a result we need to recognize the human relationship embodied in symptoms, signs, and therapy. Pearce (1989) also argues “it is too simplistic to see disease as something physical, which attacks the body”. According to him, disease causation can be due to “things we see and things we don’t see.” Many of the things we do not see are included in the African belief system such as cultural and social values, philosophies, and expressions. The common element in the African belief system is simply that physical and mental illness is the result of distortions or disturbances in the harmony between an individual and the cosmos, which may mean family, society, peers, ancestors, or a deity.

According to Lambo (1978) for example, the African way of thinking does not draw a line between the living and non-living, natural and supernatural, material and immaterial, or conscious and unconscious. These sets of phenomena, which in the West are conceived as opposites, are understood in Africa as unities. The seen and unseen exists in a dynamic interrelationship. Past, present, and future harmoniously weave one into another. The dream world and the daylight world have equal reality. In Western culture, there tends to be a distinction between physical and mental, therefore there are separate services and programs designed to treat individuals for physical ailments and for mental health difficulties (Nguyen, 1999; Gaines, 1998). In many African countries, however, including West African countries, concepts of health and well-being pertain
primarily to physical or biological health not mental health (Nguyen, 1999; Gaines, 1998). When West African individuals complain of health problems, they usually refer to physical symptoms (Nguyen, 1999; Gaines, 1998).

Mental illness is extremely stigmatizing in many African cultures. In that part of the world some forms of mental illness, such as schizophrenia or unrefined brain disorders, are conceived of as supernatural punishments for wrongdoing, and as such necessitate intense shame and stigma (Gaines, 1998; Nguyen, 1999; Okafor, 2009). Consequently, many Africans are reluctant to use mental health care, or would delay seeking care until symptoms become unmanageable (Nguyen, 1999). Among African immigrants in America, a reluctance to seek professional help of any kind and professionals’ inadequate knowledge and awareness of the impact of cultural differences in the assessment and treatment of mental illness are additional barriers to their use of the mental health care system (Gaines, 1998; Idemudia, 2004).

West African immigrants make up the fastest-growing ethnic community in California, and this is especially true in Northern California. This is a critical research issue in Northern California, as growing population diversity raises concern for increased sensitivity to, and respect for, differences in beliefs and cultural practices. There are also the overarching systems of values and norms, which perpetuate patterns of mental health. Cultures develop treatment models that reflect their own values. Unfortunately, most research literature originates in Western cultures producing an ethnocentric view of psychopathology that can limit our understanding of disorders in general, and can also
limit and restrict the way African immigrants approach treatment (Gaines, 1998; Idemudia, 2004).

According to Gaines (1998), the act of seeking professional psychological help varies across cultures. A range of factors including age, ethno-racial group, gender, nationality, religion, and socio-economic status, influences the act of help seeking. Help seeking is a multi-faceted topic; cultural differences in relation to help seeking will be the focus of this study. Cultural norms, beliefs, and values play a significant role in determining an individual’s perspective towards mental health and mental illness. Factors such as opinions about and attitudes toward mental illness, initial recognition of psychological distress, attitudes toward seeking and utilizing mental health resources, and the type and nature of mental health treatment received are all influenced significantly by an individual’s cultural and social norms.

In recent years the intersection of culture and mental health has proven to be of increasing interest to professionals in the psychiatric and mental health fields. This is evident by the growing number of research studies and clinical reports found in the psychiatric literature that addresses the influence of culture on mental health. Notwithstanding these developments, there is evidence that empirical investigations of mental health issues pertaining to Africans in the United States continue to lag behind the volume of research conducted on other minority groups (Wong, 1997; Gaines, 1998; Betancourt, et al., 2000). Yet the increasing number of Africans in the United States demands the attention of mental health professionals. It is clear that the mental health and
well being of all Americans in the United States must include the unique mental health needs of its African residents as well (Gaines, 1998; Okafor, 2009). Since help seeking behaviors are unique to specific cultural groups, this research examines the difference in the attitudes of West African Immigrants towards psychological help.

Statement of Problem

West Africans often perceive mental, emotional, and behavioral disorders not as medical conditions requiring professional services, but as spiritual diseases requiring spiritual solutions. They may attribute these problems to demons, karma, voodoo/witchcraft, ancestral service (appeasing the spirits of deceased ancestors), or lack of moral strength. This worldview of African immigrants makes it difficult for them to seek professional help when faced with mental illness. When it is felt that these mental or emotional problems cannot be adequately dealt with within the family system, West Africans usually resort to visiting traditional healers, pastors, imams (Muslim clerics), prayer houses, and religious crusades/revivals. Among West Africans there is a lack of information about the current scientific understanding of mental illness. There is also a paucity of trained professionals in mental health in West Africa. Lack of adequate media coverage of mental health issues contributes to the neglect of mental health problems. Research has shown that West Africans underutilize mental health services, despite the reality of psychological problems within the West African community (Gaines, 1998). The underutilization of mental health services has been attributed to specific cultural beliefs that discourage the disclosure of mental health issues to professionals in the field.
Other correlations to underutilization have been found by evaluating the stigma associated with mental health problems, as well as the disparate beliefs between practitioners and clients. Research in this field continually attempts to understand the needs of West Africans, in order to promote greater mental health through cultural awareness.

In this study, apart from exploring the African Immigrant attitude towards seeking professional help, the researcher will focus on the role culture plays in seeking mental health services. The way in which culture affects psychosocial health, both positively and negatively, and healing from the African perspective will be reviewed within the framework of the links between indigenous theories of conflict/stress, solidarity, and breakdowns. Not only do cultural definitions influence the interpretation of an event as stressful, but our understanding of the role of life events depends on the models of the mental health practitioner (Okafor, 2009; Thomas, 2008). For the mental health worker, the challenge is to detect the ways in which the interplay of social facts and relationships affects the patients’ mental health. Therefore, it is important for every mental health worker to know, understand, and be familiar with the cultural dynamics of the society he or she is working in (Idemudia, 2004). To see mental health and psychotherapy through the eyes of African immigrants, we must first know and understand clearly what mental health is all about and how it is conceptualized from the African perspective (Okafor, 2009; Surgeon General’s Report, 1999; Thomas, 2008). Only then can we begin to appreciate the most appropriate psychotherapeutic approaches to treating these problems.
While trying to provide explanations for the relationship between culture and health, Thomas (2008) observed that health and or illness are culturally defined and treated, since cultural meaning systems inform aspects of illness, and some diseases are culturally specific. This observation implies that culture is a way of life of a people within the same given boundaries. How does this way of life within common boundaries reflect on mental health or psychosocial disorders or even on possible recovery from psychological problems?

In general there has been a wide discrepancy in the research on the factors that influence the use of mental health services. Fischer and Turner (1970) proposed that attitudes toward seeking professional psychological help influence the use of mental health services. Additionally, Leong and Zachar (1999) indicated that opinions about mental illness play an important role in help seeking attitudes of individuals and the use of mental health services. However, a review of the related literature on attitudes toward seeking mental health services, and opinions about mental illness, reveals very little consistency in socio demographic variables on attitudes towards seeking professional psychological help and opinions about utilizing mental health services.

Purpose of the Study

Mental illness, emotional instability, and behavioral problems are often associated with stigma and shame in West Africa. West African immigrants, especially those in Northern California, are faced with acculturation and other issues that affect their mental health. There are more available services for those seeking or needing psychological help
in Northern California compared to West Africa. However, the stigmatizations of mental, emotional, and behavioral disorders in the immigrants’ countries of origin often influence the utilization of the resources and services available to them in Northern California. This study will explore the attitudes of West African immigrants in Northern California towards seeking mental health services, and whether they have experienced a paradigm shift in their thoughts regarding mental illness. I will attempt to explore the predictive value of the model minority, construct cultural congruity, home of origin, and acculturation on the attitudes of West Africans toward mental health services. This study will hopefully provide insight into the psychological and cultural issues that are pertinent to West Africans.

Attitudes play an important role in determining one’s subsequent behavior. A review of the literature indicates that Africans in the United States under-utilize mental health services in proportion to the number of potentially treatable problems (Gaines, 1998). One reason underlying the general hesitancy of Africans to use mental health services may be an unfavorable attitude towards seeking out and using these services. According to the *Diagnostic and Statistical Manual of Mental Disorder Text Revision*, the impacts of culture and belief systems on attitudes toward mental illness are major factors in their diagnosis (DSM-IV-TR) (American Psychiatric Association, 2005; Surgeon General, 1999). These factors affect the ways in which a person from a given culture communicates and exhibits symptoms of mental illness. For example, it defines a person’s coping skills, how a person’s family and community supports and responds to
mental illness, and their help seeking behaviors, like the willingness of the person to pursue or not pursue treatment (Gaines, 1998). Additionally, language plays an important role in how a person communicates mental health issues or problems; however, a person’s inability to express their symptoms can influence and even change the attitude of their mental health provider. An understanding of these issues can assist mental health professionals in the planning and implementation of culturally sensitive mental health services for African clients in the United States.

In order to investigate attitudes toward seeking psychological help among a specific community, namely West African immigrants in Northern California, one must explore some of the factors that may impact these attitudes. These factors include degree of acculturation, opinions about mental health, and the relationship between opinions about mental illness and attitudes toward seeking professional psychological help (Betancourt et al., 2000; Okafor, 2009; Surgeon General, 1999)

Significance of the Study

If attitudes towards seeking mental health services by West African immigrants in Northern California are significantly different from the attitudes in West Africa, then it could be posited that by increasing the availability of resources, services, and information related to mental health in West Africa, more people will seek professional services. If the attitudes of the immigrants remain the same in both West Africa and Northern California, then it could be assumed that providing these immigrants with a more
culturally sensitive education about mental health and increasing their awareness of culturally competent mental health providers may be necessary to influence their attitude.

Few cultures embody more striking dissimilarities to the United States than do the African cultures. These differences are reflected in their language, customs, personal beliefs and values, healing practices, life experience, and even their treatment by the majority culture (Wong, 1997). However, just as the term “American” reflects a wide variety of different regional and ethnic cultures, so too is “African” merely a general description that encompasses people from diverse, heterogeneous backgrounds (Thomas, 2008; Wong, 1997). A breakdown of the African category reveals distinct cultures from countries such as Ghana, Nigeria, Mali, Liberia, Gambia, Sierra Leone and many more along the West African Coast. Thus, it is clear that when referring to Africans we are not talking about a unified, easily stereotyped, single entity, but about many groups, each with its own history and traditions (Gaines, 1998; Wong, 1997). There is evidence that treating Africans as a single category when conducting mental health research can lead to erroneous conclusions (Idemudia, 2004; Wong, 1997). Such results can have unintended and even detrimental effects in mental health service planning and resource allocation (Wong, 1997).

Therefore, in order to reduce the possibility of generating misleading conclusions, this study focuses on a specific African culture, namely West African Immigrants in Northern California. Such a specialized focus is useful because it provides an opportunity to investigate the unique mental health attitudes and issues of this population. Even with
this narrow focus, there is still some degree of variability, due to such factors as country of origin, and the political system in the home country. Therefore, throughout this study references to mental health issues are made to West African populations and samples in the United States whenever possible. However, because the number of research studies that focus on this specific population is not extensive, references are also made to mental health issues that are common to all Africans living in the United States (Thomas, 2008; Wong, 1997).

This study focuses solely on attitudes and issues surrounding voluntary mental health treatment. The decision to seek voluntary treatment for mental health problems are greatly influenced by an individual’s attitudes and by the attitudes of his or her significant others towards receiving mental health services. Gaines (1998) called this attitudes-behavior link the “theory of reasoned action,” whereby one’s behavioral intention, which closely approximates the action of behavior itself, is determined largely by the combination of one’s attitudes and one’s beliefs about what other people think one should do, and one’s motivation to comply with these other people.

The link between an individual’s attitudes and his or her subsequent behaviors can provide much needed insight regarding cultural differences in help-seeking behaviors, such as the use of mental health services, particularly in instances where attitudes and behaviors are contradictory. Researchers have recognized that ethnicity continues to play a role in understanding the utilization patterns of mental health services among different ethnic populations in the United States. A number of studies document the fact that
utilization rates for mental health services by Africans in the United States are disproportionately low when compared to the number of potentially treatable problems (Gaines, 1998; Kamya, 2001; Wong, 1997). Therefore, in order to effectively address the mental health needs of African populations in the United States, it is crucial for psychiatric nurses and other mental health professionals to understand the reasons that underlie these patterns of treatment underutilization.

An individual will tend to seek out professional help when there is a great enough need for it, regardless of his or her expressed attitude towards using professional psychological help (Gaines, 1998; Wong, 1997). Research shows that Africans in the United States generally do not seek out mental health resources, and that they tend to wait until a psychological crisis overwhelms them before they seek help or are brought in for assistance (Berry, 1980; Wong, 1997). This hesitancy to utilize mental health resources also holds true for West African Immigrants in the United States.

These patterns of help seeking behavior have led many mental health professionals to erroneously conclude that Africans as a group have a lesser need for mental health services than do Caucasians, when in fact the issue is not one of need, but of resource utilization (Vaughn & Holloway, 2009; Wong, 1997). Because one’s attitude is an important predictive component of one’s subsequent behavior, it is important for psychiatric nurses and other mental health professionals to understand cultural differences in attitudes toward seeking professional psychological help. Such an understanding would certainly assist mental health professionals in determining possible
reasons for African clients’ treatment resistance or premature termination of treatment, as well as provide an overall framework from which mental health professionals can more effectively plan treatment strategies for these clients. Finally, having an understanding of Africans’ help-seeking attitudes will facilitate the planning and delivery of preventive mental health services to this population, so that Africans will be encouraged to enter into the mental health care system before psychological problems become unmanageable. In order to better understand West African Immigrants health, it is essential that health care providers understand the nuances of working with West African immigrants, including cultural differences, strengths, challenges and perceptions in order to provide these individuals with the most effective health care services (Vaughn & Holloway, 2009).

Theoretical Frameworks

Let us look at the theoretical frameworks that guide this study. In order to understand what governs West African immigrants’ attitudes towards seeking mental health services, the researcher used five sets of prescriptive lenses. Two frameworks, ecological and psychological, are the primary frameworks used, while three other frameworks, anthropological, general systems theory, and strengths/empowerment perspectives, are also useful but secondary in importance. Depending on the set of prescriptive lenses used reality becomes multifaceted, because one sees the world with a different focus whether one wears a cultural anthropologist’s or a psychologist’s glasses. What is seen clearly with one set of lenses may be blurred using a different theorist’s “correction,” because each theoretical framework focuses on a different dimension of
reality. As can be seen, these coexisting theoretical frameworks concentrate on different aspects of the real world’s diversity in mental health utilization (Winton, 1995) and cultural influences in perception of mental health services. Many theoretical perspectives have been advanced during the study of cultural transitions. However, some common meanings have emerged, and are now widely shared (Berry, 1997).

The ecological perspective focuses on the person in the environment (person in situation), specifically how the person interacts and therefore changes their environment in much the same way that the environment influences the individual. The ecological perspective considers the nature of a person’s behavior within their environment as proactive, inseparable, and multi-systemic. The ecological approach to human behavior is that the person and his or her environment form a unitary system or ecosystem in which each shapes the other reciprocally (Greene, 2008).

From an ecological perspective, competence, or the ability to be effective in one’s environment, is achieved through a history of successful transactions with the environment. The ecological perspective suggests that people connect with and act simultaneously within several systems (Greene, 2008). The ecological perspective on development not only examines personal or individual factors that propel development, but also explores the complex network of forces that affect the individual through behavioral settings. Ecological approaches emphasize the connections among individuals at various system levels. Bronfenbrenner (1979) conceptualized the nature of the ecological environment as a set of nested structures, each inside the next, like a set of
Russian dolls. He further described an individual’s environment as a hierarchy of systems at four levels that may be thought of as ever-widening concentric circles of environment that surround the individual, moving from the nearest to the most remote. The levels Bronfenbrenner (1989) identified are the microsystem (comprised of family, religious setting, peers, and classroom); ecosystem (school, community, mass media, and health agencies); and macrosystem (political system, economics, society, culture, and nationality). Bronfenbrenner (1989) suggested that people are both the products and producers of their development. This stems from the belief of ecological theorists that people are active, goal seeking, purposive beings who make decisions and choices. In this, the individual has the potential not only to create a response to the environment, but also to create the external reality and thereby influence the subsequent course of his or her psychological growth throughout the life course (Bronfenbrenner (1989). The manner in which the ecological perspective applies to this study is twofold. First, the greater community that is providing necessary services affects an individual, as the individual is either unaware of the services available, or is aware of resources but does not know who to approach to receive them. Second, an environment made up of individuals without health insurance has a significant impact on the health and well being of the entire densely inhabited community. Furthermore, ecological thinking suggests we should be less concerned with causes than with consequences, and that we should concentrate on changing maladaptive relationships between people and their environments.
The psychological model is best explained by Berry (2003) in his Models of Acculturation. He has extrapolated his psychological model of acculturation to include an explanation of the attitude of the larger society by proposing a four-fold model of dominant group attitudes towards acculturation. This includes multiculturalism, which parallels the construct of integration; melting pot, which parallels the construct of assimilation; segregation, which parallels the construct of separation; and exclusion, which parallels the construct of marginalization. It is well documented in the psychiatric and mental health literature that the mental health needs of Africans in the United States do not correspond proportionately to their rates of utilization of mental services. This discrepancy between resource need and utilization is due to a number of variables, all of which are related to differences between the African and Caucasian cultures. Discrepancies can occur between an individual’s attitudes and his or her subsequent behavior because behaviors are triggered by a complex interaction of attitudes, values, and situational variables (Wong, 1997). An individual’s attitude towards seeking professional psychological help is only one of several variables that enter into the equation in determining the individual’s help-seeking behavior. Other variables include the need for professional psychological help and barriers toward the use of professional psychological help.

The lesser frameworks include the Anthropological Perspective. According to the anthropological perspective as posited by Redfield, Linton, and Herskovitz (1936), acculturation occurs when groups of individuals from different cultures come into
continuous contact with each other, and, subsequently, there are changes in the original
cultural patterns of either or both groups. Redfield et al. (1936) were clear about the
importance of continuous first-hand contact between individuals of different cultures as
the essential ingredient of acculturation.

General systems theory focuses on how human systems interact. It focuses
especially on how people grow, survive, change, and achieve stability or instability in the
complex world of multiple systemic interactions. It is also a distinction framework for
understanding the organizational qualities of a social system of any size and the dynamic
interaction of its members (Greene, 2008).

The strengths/empowerment perspectives, place a high premium on human beings
as purposeful organisms. People have desires, goals, ambitions, hopes, and dreams. All
people possess a wide range of talents, abilities, capacities, skills, resources, and
aspirations. No matter how little or how much may be expressed at one time, a belief in
human potential is tied to the notion that people have an untapped, undetermined
reservoir of mental, physical, emotional, social, and spiritual abilities that can be
expressed (Rapp, 1998). But for people with serious mental illness, their lives since the
onset of their illness have been marked by pain and suffering, disappointment and failure,
and an overwhelming message of what they cannot do. As with other oppressed people,
their aspirations often are few, and non-specific (Hepworth, Rooney, Rooney, Gottfried,
& Larsen, 2006). In addition, empowerment is the process of increasing personal,
interpersonal, or political power so that individuals can take action to improve their life
situation (Gutierrez, 2001). The empowerment approach is a perspective on practice that provide a way of thinking about and doing practice.

Study Questions

RQ1: Are West African immigrants in Northern California open and comfortable in admitting they have mental, emotional and behavioral problems?

RQ2: Are they open and comfortable with seeking mental services from qualified Professionals in Northern California?

RQ3: What factors (education, economy, acculturation, access to information) influence the Immigrants’ attitudes towards seeking mental health services?

RQ4: What barriers are preventing the use of mental health services by West African service Users and their families?

Definition of Terms

Acculturation: On the scholarly level acculturation has come to include many different things—there have been anthropological constructs, psychological constructs, and sociological constructs (Shaub, 2007; Dixon, 2008). Acculturation comprehends those phenomena which results when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups (Redfield, el al., Herskovits, 1936). Acculturation is evident at the societal level and at the individual psychological level (Berry, 1980).
Adaptation: Refers to changes that take place in individuals or groups in response to environmental demands. In the recent literature on psychological adaptation to acculturation, a distinction has been drawn between psychological and socio-cultural adaptation (Berry, 1994; Berry, 1980).

Assimilation: Refers to the mode of acculturation where a person favors the dominant culture and disfavors their culture of origin. Furthermore this person integrates into his or her socio-cultural worldview values and beliefs of the dominant culture while abandoning the values and beliefs of the culture of origin (Rudmin & Ahmadzadeh, 2001; Rudmin, 2006).

Attitude: An attitude is an individual’s disposition to respond favorably or unfavorably to an object, person, institution, or event, or to any other discriminable aspect of the individual’s worlds. This definition is favored in this study because of its evaluative nature, which refers to overt or covert evaluative responding of cognitive, affective or behavioral responses (Fink & Tasman, 1992).

Culture: One significant aspect of human is culture, the configuration of shared attitudes, values goals, spiritual beliefs, social expectations, arts, technology, and behaviors, those characteristics a broader society in which people live. It is vital for helping professionals to learn to understand and appreciate the various cultural value, beliefs, and practices of their target population. A goal is to achieve cultural competency, the mastery of a particular set of knowledge, skills policies, and programs used by helping professionals that address the cultural needs of
individuals’ families, group, and communities (Lustig & Koester, 2003). Moreover, the integrated pattern of human behavior that includes thoughts, speech, customs, beliefs, values, social forms and material traits of racial, religious or social groups. Culture also helps to define family system, social relationship, child rearing practices, perception/beliefs on health, mental health, and substance abuse issues, help seeking behaviors, and communication patterns (Lustig & Koester, 2003).

Integration: Refers to the mode of acculturation in which an individual favors both the dominant culture and their culture of origin. Furthermore, this person integrates into his socio-cultural worldview, values and beliefs of both the dominant culture and their culture of origin (Berry, Kim, Young, & Bujaki, 1989; Rudmin & Ahmadzadeh, 2001; Rudmin, 2006).

Marginalization: Refers to a mode of acculturation where a person disfavors both their culture of origin and the dominant culture. Furthermore, this person rejects integrating or retaining in their socio-cultural worldview the values and beliefs of the dominant culture or their culture of origin (Rudmin & Ahmadzadeh, 2001; Rudmin, 2006).

Mental Health: Mental health is fundamental to health and human functioning; yet much more is known about mental illness than about mental health. For the purpose of this study, mental health is defined as the successful performance of mental function, resulting in productive activities, healthy and fulfilling relationships
with others, and the ability to adapt to change and to cope with adversity (Fink & Tasman, 1992).

Mental Health Issues: Signs or symptoms of a mental health problem may be present but lack the intensity or duration to meet the *Diagnostic and Statistical Manual of Mental Disorder Text Revision (DSM-IV TR)* criteria (American Psychiatric Association, 2005).

Mental Illness: Refers to all mental disorders, which are health conditions characterized by alterations in thinking, mood, or behavior (or a combination) associated with distress and/or impaired function. According to the DSM-IV diagnosis, mental health, mental problems and mental illness can be viewed as part of a continuum. The observable mental, emotional, and behavioral symptoms are only the external part of the illness. There are also abnormalities in the internal machinery of the mind and emotions the nervous systems glands, circulatory system, and the physical, chemical, and physiological processes through which these systems operate (Milt, 1974). We think and feel not only with our minds but also with our bodies. When something is wrong with a person’s mind or emotions, something is also wrong in the functioning of the bodily processes. Whether the basic cause is psychological or physical or a combination, the result is a personality marked by abnormal behavior.

Separation: Refers to the mode of acculturation where a person favors their culture of origin and disfavors the dominant culture. Furthermore, this person rejects
integrating into their socio-cultural worldview the values and beliefs of the
dominant culture, while retaining the values and beliefs of their culture of origin
(Berry, Kim, Young, & Bujaki, 1989; Rudmin & Ahmadzadeh, 2001; Rudmin,
2006).

Somatization: Symptoms of a physical illness that cannot be explained in medical terms;
Somatization is thought to mask psychiatric symptom distress or mental illness.
Somatic symptoms may be a more acceptable way of expressing suffering than
psychiatric disorders (American Psychiatric Association, 2005).

Stigma: Based on socially determined notions of what is or is not “normal” or “ordinary”
in a particular social context. Stigma is defined as “an attribute that is deeply
discrediting.” It is not the attributes themselves, but the meaning of those
attributes that determines the stigma. One of the strongest deterrents to seeking
mental health care is the stigma associated with mental illness in our society.
Stigma affects not only those seeking treatment but also their families and
caregivers (Fink & Tasman, 1992).

Limitations

In this research, some of the limitations that the author faced included
participants’ lack of openness to talk about issues considered culturally taboo. Another
limitation, despite the immense amount of literature concerning the mental health issues
of immigrant and refugee populations in the United States, is the limited research
addressing the psychological impact of immigration on African populations. Specifically,
no one has written on West African attitudes toward seeking mental health services in Northern California. Because there has not been research done focusing on West African’s mental health service utilization the impact of the number of years spent in the United States and its effects on mental health services utilization may be difficult to capture in this study. Other limitations include the fact that the findings of this study should only be applied to the West African immigrant population in the Northern California region, and cannot be generalized to any other population, because it was conducted using purposive sampling, and not random sampling which limits the internal validity of the data. Further research using larger and more systematic sampling procedures that will permit generalization is recommended.

Assumptions

The primary assumption of this study is that acculturation plays a role in the utilization of mental health services because of attitudes generated by the impact of acculturation. It is generally assumed that immigrants are more vulnerable to mental disturbances due to their migration experiences (Berry, 1994; Helman, 1990; Hertz, 1993). It is not surprising that these experiences are considered to influence mental health. Moreover, the often confounded factors of ethnicity and acculturation may affect psychological functioning and help-seeking attitudes regarding emotional problems (Neivid, Rathus, & Greene, 1997).

There are assumptions that cultural norms prevent this particular population from utilizing the services available; that they do not have an understanding of what mental
health is. More specifically, these assumptions can conclude that West African immigrants might see mental health as a general illness or traditional folk illness that is healed through a general health provider or herbal healer. Likewise, this study makes the assumption that the definition of a mental health illness held by West African immigrants is not based on a Western way of thinking and is not identified by the DSM-VI-TR. (2005). Finally, another assumption of this research is that the cause of mental health illnesses among West Africans is attributed to non-medical reasons, such as that someone has offended the spirit of his/her ancestors, that have been in West African immigrants’ culture for centuries.

Conclusions

This review has attempted to examine some of the issues and problems with regard to West African immigrants and their attitudes towards seeking mental health services. It was obvious that there were many gaps in the literature and that much research needs to be done. Though it has been expedient to consider the five major theoretical perspectives as though they are mutually exclusive, a more accurate portrayal is that they all overlap to some extent.
Chapter 2
REVIEW OF LITERATURE

Introduction

This chapter presents an extensive literature review on West African immigrants and their attitudes toward seeking mental health services. The literature review consisted of six themes relevant to the researcher’s study: immigrants’ attitudes towards mental health; African immigration to the U.S.; African immigrants and mental health issues; West African immigration to the U.S.; West African immigrants’ perception of mental health; and the barriers to accessing mental health services by West African immigrants.

The United States of America is enriched with the cultural influence of the many immigrant families that have settled here from various countries and made America their home. Among these immigrant families are African immigrants who come to the U.S. for diverse reasons. These reasons may include but one not limited to, seeking higher education, escaping political and social unrest, desiring for economic stability, or simply for mere adventure (Kent, 2007; Ndubike, 2002; Nwokocha, 2005). Like other diverse cultural groups within the United States, these African immigrants bring their cultural values, beliefs, and norms. Often, times these cultural beliefs and practices are at variance with mainstream American culture (Jambunathan, Burks, & Pierce, 2000). All these immigrants are adrift between two different worlds and cultures. Because they come into this mainstream culture with different behavioral modes and values, they find themselves separated from the host culture. Separated from their own culture, immigrants are faced
with a high degree of uncertainty and many aspects of life are unfamiliar to them (Lakey, 2003).

Immigrants’ Attitudes Towards Mental Health

The United States is becoming more ethnically and socially diverse and is moving toward greater ethnic heterogeneity, with no ethnic majority population. For instance, California currently has no ethnic majority, with over a quarter of its population foreign born (Haub, 1995; Scott, 2002). According to Scott (2002), immigration is a process involving significant cultural and psychological changes, and, in some cases, may even lead to psychopathological reactions. Though immigrants come from different ethnic communities, the difficulties they face are the same. Problems are substantial and largely interrelated. Immigration is generally acknowledged to be a major stressor that may increase the emotional distress of an individual immigrant.

One of the major obstacles in the development of mental health services in large areas of the non-Western world is the difficulty in making culturally and linguistically specific adaptations of Western scientific approaches (Bolman, 1968). Substantial bodies of research indicate that, for people from Black and Asian or other ethnic minorities, access to, utilization of, and treatments prescribed by mental health services differ from those for White people (Lloyd & Moodley, 1992). Pathways to mental health care are important, and the widely varying pathways taken in various societies may reflect many factors: the attractiveness and cultural appropriateness of services; attitudes towards services; previous experiences; and culturally defined lay referral systems (Goldberg,
Culture is one of the imprints of mental health by influencing whether and how individuals experience the discomfort associated with mental illness (Ward et al., 2001). When conveyed by tradition and sanctioned by cultural norms, characteristic modes of expressing suffering are sometimes called idioms of distress (Lu et al., 1995). It is highly imperative to note that the United States’ mental health system is based on a western and Euro-America perspective of mental health and mental illness, and it lacks understanding of how mental health is perceived among diverse cultures. This lack of cultural awareness imposes barrier that prevent people from utilizing mental health services. Minority populations such West African immigrants are often not utilizing mental health services due to barriers that are imposed through their acculturation process, such as not being able to qualify for services due to their legal status, and not obtaining services in their own language (Maclachlan, 1997; Spector, 2000).

Research into health and health-care seeking behavior amongst immigrant populations suggests that culturally based behaviors change over time towards those prevent in the host culture. Such acculturation of immigrant groups occurs as part of the interaction of immigrants with mainstream culture (Barimah & Teijjtingern, 2008). Contact with mental health care services may be imposed on the individual, but people who choose to engage with services usually do so only if they think that their changed state of functioning is health related and potentially remediable through these services (Bhui & Bhugra, 2002).
Immigration involves a process of acculturation. At a cultural level, acculturation involves adjusting to a new culture and environment. At an interpersonal level, immigration must reorganize interpersonal relationships. At an intra psychic level, immigrants must learn to cope cognitively, attitudinally, and behaviorally in a new cultural system (Barimah & Teijjingern, 2008).

The subsequent changes resulting from relocation have psychological, spiritual, affective, and cognitive consequences. There are a number of identifiable experiences of immigrant populations. Outline social isolation, cultural shock, cultural change, and goal-striving stress are four significant experiences all immigrants experience. Bhui and Bhugra (2002) pointed out that migration is a developmental process with various tasks and demands. Past studies of immigration have focused on identifying situation-specific coping mechanisms used by immigrants to confront these problems (Sluki, 1979).

The migration process, however, is a multivariable interaction among individuals’. The central aim of the field of cross-cultural psychology has been to demonstrate the influence that cultural factors have on the development and display of individual human behavior. Many psychologists working in this field have concluded that there is now substantial evidence to document the outcome of this culture-behavior relationship; individuals generally act in ways that correspond to cultural influences and expectations (Berry, Poortinga, Sewall, & Dasen, 1992). Acculturation is considered to be a matter of learning a new behavioral repertoire that is appropriate for the new cultural context. This also requires some culture shedding to occur (the unlearning of aspects of
one’s previous repertoire that are no longer appropriate), and it may be accompanied by some moderate “culture conflict” (where incompatible behaviors create difficulties for the individual.

Group-level Acculturation

With respect to group acculturation, migrant groups usually change substantially as a result of living with these two sets of cultural influences. Physical changes are often profound, frequently involving urbanization, and increased population density. Biological changes include new dietary intake and exposure to new diseases, both of which have implications for the health status of the whole group. Economic changes can involve a general loss of status or new employment opportunities for the group. Social changes range from disrupted communities to new and important friendships. Cultural changes (which are at the core of the notion of acculturation) range from relatively superficial changes in what is eaten or worn, to deeper ones involving language shifts, religious conversions, and fundamental alterations to value systems (Berry, Poortinga, Segall, & Dasen, 1992). Variability in psychological acculturation exists because of the three differing views about the degree of difficulty that is thought to exist during acculturation, which were outlined earlier (“behavioral shifts”, “acculturative stress”, and psychopathology”). According to Gordon (1964), cultural assimilation or acculturation is likely to be the first of the type of assimilation to occur when a minority group arrives on the scene. Cultural assimilation, or acculturation, of the minority group may take place
even when none of the other types of assimilation occur simultaneously or later, and only this condition of acculturation may continue indefinitely.

Gordon (1964) points out that value systems, developmental sequences, roles, and personality factors all contribute to how individuals accommodate when they come into contact with each other. This model was advanced because it specified important culture-related information that changes with intergroup contact, and what aspects of culture might be more resistant to change (e.g., values) with intercultural contact. The significance of this definition is that it provides for choice in the acculturation process—the change from one cultural orientation to another can be “selective,” and persons involved in intergroup contact can decide what elements of their culture they wish to surrender and what cultural elements they want to incorporate from the new culture.

Acculturation barriers affect the utilization of services. Many minority groups have not been served as well as the majority population or provided culturally based services. Minority populations such as West African immigrants struggle to obtain services that are culturally competent, and that are not influenced by Western perspectives (Hains, 1989; Okafor, 2009; Thomas, 2008).

African Immigration to the U.S.

The West African immigrant journey to the United States is fraught with many obstacles. Many West African immigrants come to the United States for a better way of life, the “American Dream” that every immigrant hopes for (Rundle, Carvalho, & Robinson, 2002). Oftentimes adapting to a new way of life can be mentally and
physically challenging. Although the immigration of people of African descent into this country has increased over recent decades, Black African immigrants remain the smallest number of all immigrants groups to the United States (U.S. Department of Commerce, 1995). The existing literature on African immigration examines causes of African immigration to the United States. These causes include economic problems and political instability at home, educational opportunities in the United States, reuniting with family members, and changes in immigration laws in both the United States and Europe (Berlin, 2005; Clark, 2006; Kent, 2007; Shobo, 2005; Terrazas, 2009).

The United State’s mental health system has not aimed to adapt services to the needs of African immigrants and their unique struggles of adapting to a new culture and belief system. This in itself imposes many barriers for African immigrants who suffer with mental illnesses and need treatment (Okafor, 2009; Thomas, 2008). Despite the immense amount of literature concerning mental health issues of immigrant and refugee populations in the U.S., there is limited research addressing the psychological impact of immigration on African populations (Thomas, 2008). While considerable resources have been devoted to the study of immigrants, historically there has been a lack of attention to African immigrant groups in the United States. Previous research has examined the adjustment of refugees or immigrants in terms of education; language; and economic, social, and psychological well being (Haines, 1989). Immigrants face a number of problems, including stress related to acculturation, change loss, and trauma. Immigrants may not be welcomed by the host society. This sentiment is echoed by recent legislative
initiatives in some states that propose to deny some immigrants access to social services. These new immigrants bring a diversity of skills and experiences, along with rich cultures and traditions. They are immigrants and they are black - two distinctive social groups in the United States - that influences their adaptation into the social and economic fabric of their new country. Many immigrants consciously maintain the dress, language, and other aspects of their homelands to affirm their “otherness.”

Mental illnesses are highly prevalent among immigrant populations; however, a sparse amount of the aforementioned research specifically pertains to African immigrant populations within the U.S. Furthermore, the research that addresses this specific population failed to consider a number of pertinent cultural forces that must be assessed when evaluating the mental health of immigrant populations. Thus, the purpose of this chapter is to review literature pertaining to salient cultural factors that impact the mental health of African immigrants to the U.S. More specifically, this review focuses on the impact of African culture on the following areas: (a) family dynamics, (b) symptom expression and diagnosis, and (c) mental health treatment.

According to many African cultural groups, psychophysiological complaints are often formulated as subjective bodily sensations, including the sense that the heart is melting, a desire to fly away, and a report of a lump in the throat (Ebigbo & Ihezue, 1982; Okhomina & Ebie, 1973). Several mental health researchers in Africa have described these complaints as the somatization of emotional distress (Ayorinde, 1977; Ebigbo & Ihezue, 1982; Lambo, 1963). Lin (1991) called for close adherence to the tenet
of cultural relativity, together with efforts in obtaining relevant information regarding the meaning and consequences of the symptoms in the patient’s cultural context. On the other hand, an excessive preoccupation with cultural influences in psychiatric symptom presentation may lead to underestimation of psychopathology. Lin also argued that adequate attention to the universal aspect of psychopathology is essential in counterbalancing such a tendency (Thomas, 2008).

African Immigrants and Mental Health Issues

This review provides an overview of the state of research on mental health issues of African immigrants to the U.S. African immigrants are at risk of developing mental health problems due to the unique stressors experienced during the various stages of the migration process. These stressors may include social isolation, acculturative stress, and family role changes. In some cases, these stressors may overcome African immigrant families coping and adaptation, resulting in family conflict. In addition to family conflicts, family members, particularly African youth, experience unique life cycle issues that are affected by migration, issues that center largely on identity and family expectations. Furthermore, cultural beliefs influence how African immigrants conceptualize what is normal and abnormal behavior, the etiology and symptomatology of mental health problems, and what they consider appropriate mental health treatment. The most commonly observed mental health problems among African immigrants include depression, anxiety, somatization, and Post Traumatic Stress Disorder (PTSD). The recommended treatment for addressing these and other mental health concerns
within the African immigrant population includes cognitive behavioral therapies, family therapy, and the use of psychotropic medications.

The above review of mental health issues among Africans who immigrate to the U.S. carries the risk of giving the erroneous impression that all African immigrants suffer with mental health problems. It is crucial to remember that in reality most African immigrants do not develop severe mental health problems (Potocky-Tripodi, 2002). Although researchers argue that all immigrants and refugees experience various migration stressors, in most cases significant mental health problems are prevented.

West African Immigration to U.S.

The United States has the largest number of educated West African immigrants living and working in Western nations. Almost all of the African immigrants who have emigrated to the U.S. did so in the post World War II era. In 1960, for example, there were only 35,000 African immigrants in the United States (Profile of the Foreign Born Population, 2001; Spector, 2001). By the year 2002 that figure had increased to just over one million (American Community Survey Profile 2002, 2003). Just as most African slaves were brought to the United States from West Africa, so also are West Africans the highest proportion of all African immigrants immigrating to the United States in the post World War II Era. This is a contributing factor as to why West Africa is still underdeveloped, because for hundreds of years that region has been losing its talented people to Western nations and other parts of the world.
According to the United States Census Bureau, as of the year 2000, there were an estimated 881,300 African immigrants in the United States. Of that number, West African immigrants comprised 37% (326,507 of the total African immigrants), with Nigerians comprising 41.3% (134,940), Ghanaians 20.1% (65,572), and Sierra Leonians 6.4% (20,831) of the West African total (Kaba, 2007; Karim 2009).

Research is needed to better understand the impact of migration on West African immigrants’ mental health and their ability and willingness to seek traditional Western care. Therefore, the present quantitative study investigated the variance in attitudes toward seeking psychological help as predicted by degree of acculturation, severity of self-reported problems, and beliefs about the cause of mental health problems among West African immigrants in the U.S. (Okafor, 2009; Thomas, 2008). West African immigrants reported various concerns with their mental and physical health. In general, they reported preference for the use of informal systems of support to resolve their emotional concerns, and the use of medical doctors for physical concerns (Thomas, 2008).

**West African Immigrants’ Perceptions of Mental Health**

Lum (2003) in his book, Culturally Competent Practice explores how meaning is acquired through cultural influences. In focusing on how meaning impacts the way a person perceives mental health, Lum points out:

Cultural meaning systems are relevant in the diagnosis and treatment of mental illness in the cultural environment. There is a framework for how mental illness is
given cultural meaning (symptoms, perceptions, relationships, explanations), which then shapes the way that one suffers and copes with mental illness. First, meaning is given through symptoms (sensations, thoughts, emotions, behavior) interpreted as an indication of illness. Second, meaning is given through cultural significance or societal constructions of what mental illness is and how society views the person and the mental disorder. Third, mental illness has cultural meaning through personal and social relationships, including relationships in the family and workplace. And fourth, the explanatory model or how mental illness is explained (onset, effects, course, treatment) can affect the diagnoses of clinicians as well as the subjective experiences of mental patients. (p. 292)

The traditional African definition of health stems from a belief about life and the nature of being to the West African, or African as a process rather than a state. The nature of a person was viewed in terms of energy force rather than matter. All things, whether living or dead, were believed to influence one another. Therefore, one had the power to influence one’s destiny and that of others through the use of behavior, whether proper or otherwise, as well as through knowledge of the person and the world (Spector, 1996). When one possessed health, one was in harmony with nature; illness was a state of disharmony. Traditional African belief regarding health did not separate the mind, body, and spirit. Disharmony, that is illness, was attributed to a number of sources, primarily demons and evil spirits. These spirits were generally believed to act of their own accord,
and the goal of treatment was to remove them from the body of the ill person (Spector, 1996, 2000).

There are other factors beyond this traditional view of health that affect how West African immigrants respond towards mental health and mental illness. Limitations such as the lack of research undertaken amongst the West African immigrant population, and the meaning and perspective of mental health creates barriers in receiving services that are bilingual and culturally competent (Mohamed, 2003; Spector, 1996).

This researcher has also attempted to define some of the cultural barriers that may be significant in explaining a set of mechanisms that facilitate or hinder the seeking of psychological help by West African immigrants within given psychotherapeutic relationships. Any shameful event that might bring disgrace to the family and the tribe is completely avoided. This may be attributable to rigidity in perception, rather than to a distorted misattribution of what constitutes treatment. These elements, mainly existential in nature, are traditionally relegated to a more specialized individual who often employs nonmedical, non-psychological, non-cultural bound methods of healing. Traditional healers such as native doctors, witchcraft, and prayer groups and figure prominently.

Africa is a continent that is culturally diversified. Although there are cross-cultural and ethnic differences in Africa, there is nonetheless a general belief that both physical and mental diseases originate from various external causes such as a breach of a taboo or customs, disturbances in social relations, hostile ancestral spirits, spirit possession, demonic possession, evil machination and intrusion of objects, evil eye,
sorcery, natural causes, and affliction by God or gods (Idemudia, 2004; Mohamed, 2003; Nyagua & Harris, 2007).

According to Taussing (1980), the most important thing about society is the relationship between people, and, as a result, we need to recognize human relationships embodied in symptoms, signs, and therapy. Pearce (1989) also argued “it is too simplistic to see disease as something physical, which attacks the body.” According to him, disease causation is due to “things we see and things we don’t see.” Many of the things we don’t see are included in African belief systems, cultural and social values, philosophies, and expressions.

According to Tsala Tsala (1997) every disease is systematically acknowledged as having a supernatural origin—the grief of ancestors or divinities, the practice of sorcery and various evil spells. To an African, biology alone does not explain disease causation, because it is seen as a social phenomenon, and as such has significance for the whole ethnic group and immediate community members. Also, Africans believe that disease can be transmitted from one generation to another as long as the stains of a fault have not been cleansed. Many collective rites exist whose aim is to stop transmission of some diseases that run in the family.

The common element in the African belief system is simply that physical and mental illness is the result of distortions or disturbances in the harmony between an individual and the cosmos, which may mean his family, society, peers, ancestors, or a deity. According to Lambo (1978), for example, the African way of thinking does not
draw a line between the living and the non-living, natural and supernatural, material and immaterial, conscious and unconscious. These sets of phenomena, which in the west, are conceived of as opposites, are understood in Africa as unities. The seen and unseen exists in a dynamic interrelationship. Past, present, and future harmoniously weave into another. The dream world and the daylight world have equal reality. In Africa, people interact with one another not on the basis of how things are, but how they perceive them to be.

Africans perceive ill health to have material, moral, supernatural and pre-natural causes which can only be determined both by physical observation and divination. According to Tsala Tsala, (1997) this way of viewing health and disease, as a matter of harmony or disharmony between an individual and a larger context is similar to the holistic perspective being advanced currently by Western researchers, that culture influences the onset of psychosocial disorders, and mental health is a theoretical as well as a practical reality.

Taussing (1980) defines culture as the “set of attitudes, values, beliefs, and behaviors shared by a group of people, but different for each individual, communicated from one generation to the next”. From this definition he argued that culture is not rooted in biology, race and nationality. He also described the dualism in culture with the dimensions of individualism and collectivism (IC), which refers to the degree to which a culture encourages, fosters, and facilitates the needs, wishes, desires, and values of an autonomous and unique self over those of a group. Detailed descriptions of both dimensions have also been written by Idemudia (2004). According to Idemudia (2004),
both dimensions are encountered amongst different groups in different parts of the world but in different degrees. The grading of communalistic and individualistic cultures may range from very weak and passive to very strong and active.

Figure 1. The body mind psychopathology link.

Physical or Mental disorders can be attributed to:
- Breech of taboos/customs
- Disturbances in social relations
- Hostile ancestral spirits
- Spirit Possession
- Demonic possession, e.g. (Ogbanje and Mammie Water)
- Evil Machinations
- Evil eye
- Intrusion of objects
- Affliction by gods and sorcery
Figure 2. Framework for acculturation research (Segall, Dasen, Berry, & Poortinga, 1999, p. 310).

Looking at the acculturation from the lens of Berry, a psychologist, he describes the background factors involved in a specific individual’s choice of acculturation strategy as including the direct effects on him of the new culture, the adjustments being made to the new culture by the members of his original culture that form his relevant sub-group and finally the effects of that sub-group on the individual. Individual adjustments can be psychological, sociocultural or both. Additionally, adjustments run the gamut from relatively simple behavioral adjustments to complex, difficult to achieve adjustments that
can result in acculturative stress and serious psychological issues if not addressed. Also relevant are changes in the new culture coming from contact with individuals from the sub-group of the original culture. These relationships then serve as background factors as Berry’s main emphasis shifts to strategies available to the group as they proceed with the acculturation process.

Berry envisions two separate dimensions—one dealing with the original culture and the other dealing with the received culture. The original cultural dimension runs between the conditions of Separation and that of Assimilation. The dimension dealing with the new host culture runs between Marginalization and Integration. He describes the four conditions as follows:

Separation—individuals place a value on holding on to their original culture and at the same time wish to avoid interacting

Assimilation—individuals do not wish to maintain their (original) cultural identity and seek daily interaction with other cultures

Marginalization—individuals perceive little possibility and have little interest in cultural maintenance and at the same time have little interest in having the relationships with others

Integration – Individuals have an interest in maintaining their original culture during daily interactions with other groups
There is no research that examines stress and coping among African immigrants or takes into account the care and well-being of African immigrants (Kamya, 2001).

Stress, which has been defined as a nonspecific response of the body to any demand, can be studied across a range of dimensions from the cellular level to different cultural levels (Selye, 1976). For Africans, the social dimension of stress as observed in attitudinal, familial, and environmental contexts are very important (Kamya, 2001).

Figure 3. Berry’s model of acculturation.
West African Cultural Beliefs

Cultural transmission among West African immigrants is a grassroots process that influences how meaning is perceived. Mental health perspectives amongst this population are acquired through generations of cultural history and experience. Therefore, mental illness among West Africans is viewed differently than the general American population (Ramirez, 1982). Culture refers to meanings, values, and behavioral norms that are learned and transmitted in the dominant society, and within its social groups. Culture powerfully influences cognitions, feeling, and “self” concept, as well as the diagnostic process and treatment decisions. Ethnicity, a related concept, refers to social groupings which distinguish themselves from other groups based on ideas of shared descent and aspirations, as well as to behavioral norms and forms of personal identity associated with such groups (Johnson, 1988; Kroeber & Kluckhohn, 1963; Linton, 1945; Mezzich, Kleinman, & Fabrega, 1993).

Western cultures favor individual autonomy while African favors a group identity. Another significant difference between the two cultures is the concept of the body. Western societies tend to see the mind and body as separate, whereas West African societies tend to see the mind and body as a whole. Culture can influence many aspects of a person’s life, and this can be reflected in their mental wellbeing. Culture also influences self-monitoring and the initial experience of distress and dysfunction, idioms of expression, the individual’s model of illness and healing, and the presentations of psychiatric disorders (Mezzich et al., 1993). How people’s symptoms of ill health
manifest, and how they then deal with those symptoms may vastly differ from one culture to another, with some viewing mental illness as a blessing rather than a curse. Mercer (2007) posits that in some cultures if you are talking about hearing voices then you might be seen as having schizophrenia. However, in other cultures it may mean that the person is hearing the voice of their ancestor considered a positive thing and not due to a mental illness. This is a dilemma if practitioner does not understand the culture of the patient then it is very hard to treat them in a way that is really effective. Cultural differences can affect how people perceive mental health care and providers, and also how they communicate and label their symptoms. It is therefore vital for those caring for people with mental health problems to have an understanding of the person’s culture. This could dramatically influence how they can or should be treated. For the Western practitioner the more challenging aspects of other cultural traditions, such as spirit-based belief, will require openness to the guidance of non-Western colleagues and patients in order to overcome stereotypical responses (Dixon, 2008; Nyagua & Harris, 2007). Culture can shape a patient’s concept of disease, treatment, and even the existence of certain illnesses. An increased awareness of cultural differences can improve communication between the physician and the patient and improve patient compliance with other medical procedures and treatments.

People’s beliefs about illness, distress and disability profoundly influence their experience of, and responses to, such a problem. Medical anthropologists have long recognized the importance of explanatory models of physical illness and the impact of
these on the provision and use of health services. Similarly, psychological models of physical illness and related behavior stress the importance of the ways in which people conceptualize or understand their difficulties. These are central in determining emotional responses to illness, help-seeking and illness-related behaviors, and attitudes towards, and compliance, with treatment (Perkins, 1993). Eisenbruch (1990) argues, “the culturally constructed ideas held by the patient about the cause and nature of disease” are important in relation to mental distress and disturbance. Help-seeking behavior, attitudes towards, and compliance with, treatment are of central concern in psychiatry, and all of these are influenced by people’s understandings of their difficulties. Yet relatively little attention has been paid to the ways in which people conceptualize their mental diseases. Typically, mental health professionals make use of the concept of insight. A person’s understanding of their problem is seen as symptomatic of their condition. Despite suggestions that this concept of insight is of limited value, it is still very much alive in current clinical practice.

David (1990) has argued that the concept of insight should be elaborated and extended. In particular, he argues that insight should not be seen as an all-or-nothing phenomenon and that it comprises three distinct, but overlapping, dimensions: the recognition that one has a mental illness, compliance with treatment, and the ability to relabeled unusual mental events as pathological. Such a ‘reformation’ does indeed make more specific the ‘correct’ attitude to which Aubrey Lewis referred in defining insight as “a correct attitude to morbid change in oneself” (Lewis, 1934), and could undoubtedly
lead to a more uniform and less confused use of the concept. However, it does make more specific the value judgments and framework within which the concept gains its meanings.

In David’s (1990) formulation insight means not only agreeing with the doctor that one is mentally ill, but agreeing with the remediation for that illness (as defined within a psychiatric framework), and reconstructing one’s experience with the terms and concepts of Western psychiatry, rather than one’s karma or bodily imbalance or disharmony. Several studies have shown that around half of those people admitted to psychiatric hospitals lack insight in that they do not consider themselves to have a mental illness. Clearly, a significant proportion of newly admitted psychiatric patients do not concur with a psychiatric view of their difficulties.

The Communication Barriers to Accessing Mental Health Services by West African Immigrants

Communication patterns and value orientation patterns of West Africans are so diverse, because there are so many different countries and tribes in the region; communication patterns and value orientation patterns differ (Rundle et al, 2002). But all the countries and tribes have some communication patterns and values in common, such as:

Personal space between members of the same sex is very limited. West Africans tend to stand or sit very close to others when conversing.

Doctors in West Africa will discuss the seriousness of an illness with the next of kin. It is bad luck to tell the patient.
West Africans are taught to respect authority figures. They may not contradict or question a health care provider. However, this does not mean that they necessarily intend to comply with the prescribed care plan.

Communication is the tool assisting immigrants to satisfy their basic personal and social needs in the new host culture. To acculturate themselves immigrants must acquire the host cultural patterns and develop working relationships with the new environment. This cultural awareness process and the necessary adaptations are facilitated by communication. To the extent immigrants master the communication process of the host culture, they will become acculturated (Lakey, 2007). Kim (1982) has contributed the most extensive study toward defining acculturation from a communication perspective. Communication is viewed as acculturation central to the acculturation process. Thus, acculturation occurs through the identification and the internalization of the significant symbols of the host society. With communication competence central to the acculturation process, it is obvious that one learns to communicate by communicating. The acculturation process, therefore, is an interactive and continuous process that evolves in and through the communication of an immigrant with the new socio-cultural environment. The acquired communication competence in turn, reflects the degree of that immigrant’s acculturation. The acculturation process is conceptualized whereby contact with and assimilation to the dominant culture, results in a loss of distinct cultural patterns of the heritage culture (Gordon, 1964). This model posits that acculturation is unidirectional and results in inevitable assimilation over time.
Communication or lack thereof is one of the many reasons why immigrant health care presents challenges. Immigration itself can cause illness and disease due to disrupted family and social networks, financial barriers, and discrimination that prevent the establishment of a healthy lifestyle. Immigrants frequently work in low paying jobs, face poverty, lack health insurance, have limited access to health care and social services, and have communication difficulties due to language differences (Rundle et al., 2002).

Immigrants may also experience stress due to adaptation to the U.S including such tasks as learning and/or enhancing English skills, finding employment, housing, and schools, these difficult tasks for anyone, but especially for immigrants as they also deal with new and different social/cultural expectations and attitudes. Such circumstances can contribute to confusion and conflict, anomie, personal disorganization, and a variety of other problems related to social marginality (Vaughn & Holloway, 2009). Acculturative stress is the “psychological impact of adaptation to a new culture” with potential effects on physical health and self-esteem. Rapid changes in norms, institutions, and values can contribute to higher rates of mental disorders, especially with regard to depression, adjustment, and general psychosocial dysfunction all of which result from the process of adaption, accommodation, and acculturation which involve dynamic and synergistic changes in the immigrants’ intra psychic character, their interpersonal relationships, and their social roles and statuses. In the new culture, parents may have to work leaving less time with children or alternatively may have to leave their children behind in their native country. Conflicts can arise around changing relationship expectations, gender role, and
incorporating aspects of their own culture into their new culture. All of these acculturative issues can contribute to an extremely complex adjustment process that in turn affects health and well-being and seeking health care (Vaughn & Holloway, 2009).

Role of Religion

Religion plays an important influence in the West African Culture. Religion influences how West African immigrants’ view mental health (Thomas, 2005). Religion in the West African culture is a strong support system for people dealing with, mental illness. Traditional religious rituals such as prayer re often used to cope with a mental illness (Mbiti, 1989; Thomas, 2005). Prayer can be used as healing process in a person. Religion amongst West African immigrants is used as a therapeutic process that helps overcome obstacles (Mbiti, 1989). The elders in the church and the priest provide spiritual support to overcome pain and suffering.

In addition, the role of religious belief and practice are central to all aspects of life in West Africa. That is, religious beliefs impact the way people live their everyday lives. From what they eat (or cannot eat), the way they farm, do everyday chores, hunt, make tools and clothes, arrange themselves in families, marry, divide work among family members, educate their children, treat illness, and bury the dead. Among indigenous West African religions, religious belief and practice are not restricted to one holy day each week be it Friday, Saturday, or Sunday, but are present in the most common daily activities as well as in special ritual ceremonies (Mbiti, 1989; Thomas, 2005).
Furthermore, the West African worldview provides a system of values, attitudes, and beliefs, which provide the people with a mechanism to understand the world in which they live, and everyday events and occurrences. A religion provides a system of morality that establishes right from wrong, good from bad or inappropriate behavior. Just as with Islam, Judaism, and Christianity, children growing up in West African religions learn right from wrong, and what is appropriate and inappropriate behavior in every situation that they face (Mbiti, 1989).

Moreover, West African immigrants believe in the supernatural and only one supreme God who created the world and all that is in the world. According to Mbiti (1989), a leading expert on African religions, many African religions share the following concept of God:

- God is creator of all things
- God sustains creation
- God provides for and protects creation
- God rules over the universe
- God is all-powerful (omnipotent)
- God is all-knowing (omniscient-knows everything that happens in the world)
- God is viewed as parent (sometimes as a father and sometime as a mother)
- God is supports justice
- Human – being cannot know God.
These concepts are quite similar to the way God is viewed in Christianity, Islam, and Judaism, the three main monotheistic religions. Diverse cultures possess diverse religious and spiritual beliefs that are an important aspect of cultural identity and affect health (Numbers & Amundsen, 1986; Sullivan, 1989). The philosophy or value system of Africans provides some background to understanding their immigration experience. Most Africans believe in a Supreme Being who controls the natural order of things. Some Africans also believe in spirits or spiritual beings who work in concert with the Supreme Being. The African’s philosophy is life centered and is expressed in prayers, invocations, and praises. The life motif can be seen in prayers for obtaining life, restoring life, and preserving life from impending dangers; in prayers for recovery from illness; and in prayers for making life more abundant. The life motif also is the basis of the African immigrant’s well-being. Although many Africans have embraced major Western and Eastern religious traditions, strong African cultural and religious beliefs, rituals, and values permeate their self-understanding and celebration of life (Kamya, 2001).

Self-esteem is defined as one’s self-perceptions and self-valuations in personal and social contexts. For Africans, these contexts include the community, the spiritual, and natural. Spiritual well-being is defined as satisfaction with one’s religious well-being reflected in one’s relationship with a Supreme Being, one’s existential well-being, and one’s sense of meaning and purpose in life. For Africans, the spiritual has a personal and a communal aspect. It also implies the community’s preparedness and acknowledgement
of something outside itself and the community’s experience and involvement of this “otherness” (Kamya, 2001).

Self-esteem and spiritual well-being are intimately tied into the individual’s coping resources, defined as characteristics or ongoing behaviors that enable individuals and communities to handle stressors more effectively, to experience fewer symptoms on exposure to stressors, or to recover faster from exposure (Zeidner & Hammer, 1990). For Africans therefore, coping, be it cognitive or social, emotional, or physical is derived from the personal and collective understanding of the spiritual in people’s lives. Culturally rooted traditions of religious beliefs and practices carry important consequences for willingness to seek mental health services. In many traditional societies, mental health problems can be viewed as spiritual concerns and as occasions to renew one’s commitment to a religious or spiritual system of belief, and to engage in prescribed religious or spiritual forms of practice (US Surgeon General).

Many people of all racial and ethnic backgrounds believe that religion and spirituality favorably impact upon their lives, and that well-being, good health, and religious commitment or faith is integrally intertwined Mbiti (1989). Religion and spirituality are deemed important because they can provide comfort, joy, pleasure, and meaning to life as well as be a means to deal with death, suffering, pain, injustice, tragedy, and stressful experiences in the life, of an individual or family. In the family/community centered perception of mental illness held by Asians and Hispanics, religious organizations are viewed as an enhancement or substitute when the family is
unable to cope or assist with the problem. Culture also imprints mental health by influencing whether and how individuals experience the discomfort associated with mental illness. When conveyed by tradition, and sanctioned by cultural norms, characteristic modes of expressing suffering are sometimes called “idioms of distress” (Lu et al., 1995). Idioms of distress often reflect values and themes found in the societies in which they originate.

Belief in West African Traditional Medicine

Cultural factors tend to encourage the use of family, traditional healers and informal sources of care rather than treatment-seeking behavior (Uba, 1996). Peter (2003) posits that medicine in Africa is regarded as possessing its own "life force", not just using a system of prescribing. This is because health problems are not only attributed to pathological explanations alone, but also to other "forces". Hence, traditional healers utter incantations to take care of negative forces that militate against achieving a cure.

Treatment in African traditional medicine (ATM) is holistic. It seeks to strike a balance between the patients' body, soul, and spirit. Problems arise from the infiltration of charlatans into the field, the practice of using mystical explanations for ill health, and inadequate knowledge of the properties and clinical use of herbal remedies. Despite its problems, ATM can work in parallel with orthodox medicine using its strengths rather than its weaknesses. ATM has to be applied within a uniform ethical system. In addition, the role of and traditional medicine in West African is still of much relevance to health care delivery in the African continent. Western cultures Version of health care is very
expensive, in short supply and unreachable for the people in rural areas. The economic situation on the African continent equally encourages the use of traditional medicine that is less expensive; hence it is more available and affordable to the local/rural populace. The expectation in African medicine is to perfect or modernize it as it is comparable to the Western Version of medicine (Peter, 2003).

The desire to evaluate the potential contribution of folk doctors to community health care, ties up with the value of folk knowledge and curative or preventive health practices, a point being raised with increasing urgency by the health officials of the world’s younger nations. The care provided by traditional healers or folk doctors is rooted in age-old customs and, like them, quite often constitutes the very heart of culture. These types of medicine are incorrectly called “parallel or alternative medicine” in contradistinction to Western medicine, only recently introduced in Central Africa. This fact makes it impossible to imagine a central health care system separate from the African culture out of which it draws its meaning. Medical anthropologists must thus adopt a holistic anthropological perspective in dealing with such systems.

In many African countries there is a growing awareness that a national health plan cannot rely on the all too expensive cosmopolitan medicine alone, but must also include the positive contributions of traditional medicine (Akerele, 1984). Bibeau reports that, as each African village has its own healer, many countries are starting to wonder whether the healers might feasibly be turned into primary health care workers at minimal expense (Bibeau, 1984). With the scale of the problems posed, there is a great deal of debate
about how mental illness is understood and defined across different cultures and traditions and how this may influence society’s response about the mental health in the country (Quinn, 2007). Generally speaking, there are two systems for explaining mental illness: the biomedical, with an emphasis on the diagnosis of symptoms, which are treated primarily through medical interventions; and traditional, which attributes mental illness to many causes such as witchcraft, curse, or evil spirits and is treated by herbal or spiritual means (Quinn, 2007). According to Ngong The (1998), the involvement of the community as a whole is very important in traditional systems.

This is part of the integrative function of a traditional setting; healers perform social therapy to restore harmony to the group. If there is the belief that the illness is caused by a breakdown in relationships within the neighborhood by, for example, a property dispute between two families, the curing of illness requires the establishment of social relationships (Ngong The, 1998). The traditional healer actively seeks the involvement of the local community in the healing process. At times the local community’s structures may serve as a form of social control, such as when the person with mental health problems is physically restrained, although there may be occasions when the family may need to use physical restraint if they are having problems controlling behavior. Throughout the entire therapeutic process the family plays a very important and central role. Concerned family members may assemble to decide how to deal with the problem. Many West African countries see no discrepancy in attributing the etiology of disease to both naturalistic (biological) and supernatural causes (Henry,
The uses of indigenous medicines in West African countries are common, and most individuals have some knowledge of certain plants that may be self-applied in times of sickness. Most West African countries have an assortment of indigenous healers, including herbalists, Muslim clergy, society elders, bone specialists, and, increasingly, faith healers (Henry, 2004). It is important to know that oftentimes, supernatural treatments are complex rituals. Many West Africans, for example, offer prayers or sacrifices to ancestors, practice or subscribe to traditional prophecy or divination, or use charms to ward off evil spirits or witchcraft along with Christian or Islamic worship (Henry, 2004). Although there is great variation within indigenous religions, nearly all share beliefs in (a) one supreme creator of the universe; (b) other gods and spirits present in virtually all of nature, e.g., trees, rivers, and rocks; and (c) ancestral spirits that may help individuals provided appropriate rituals are followed (Henry, 2004).

In Igbo perception, every ailment comprised the invisible, spiritual or supernatural origin and the visible or natural origins. Hence they commonly perceived ailments especially the protracted ones like insanity, as dual rooted. As Nwoko (2009) puts it, for Igbo, health is something shared inter-corporeally and inter-subjectively, both in the worldly and other worldly or visible and invisible realms (Nwoko, 2009).

Generally, insanity refers to “behavior at odds with the expected proper behavior in the household and society. Both orthodox and traditional conceptions of insanity are agreed on the pathology of insanity as well as its manifestations: loss of rationality, a significant impairment of thought, emotional instability, distorted perception, and wrong.
The conception in traditional Igbo society transcended this, it was believed that the evident irrationality was only a physical or human interpretation of the metaphysical interrelation between the victim and the exerting external force or entity. And this transcended the human rationality. While it is noted in the Igbo language that when a person goes insane they lose all thoughts of reality, hence the saying, the insane is conscious of his actions but unconscious of his afflicter. They murmur nonsense because they have a heightened sense of receptivity with some personalities and forces invisible to the human eyes and perception (Nwoko, 2009).

Stigma and Shame About Mental Illness

The stigma of mental illness is another factors that preventing West African immigrants from seeking treatment (Snoweden, 1999). The stigma associated with mental illness can have an impact on the level of social support offered (Quinn, 2007). The degree of stigma experienced by a person with mental health problems in an African context is often influenced by whether the person is blamed for having the illness or the blame is on other supernatural, unseen and spiritually driven forces. According to Quinn (2007), other researchers have found that sometimes, depending on the society, some blame the person with mental illness but in other communities, the mentally ill is held blameless for his condition because it is believed to be caused by social and spiritual forces beyond his /her control. Cheetham and Rzadkowolski (1980) suggest that attitudes towards mental illness are culturally dependent and found that pastoral societies are more tolerant of people with psychosis and have fewer illness taboos than do industrial
cultures. A family member’s illness is considered a threat to the homeostasis of the family, which often leads to the mobilization of the family’s resources. Help seeking typically is a joint family venture rather than a personal decision (Lin & Cheung, 1999).

In addition, amongst West African immigrants the traditional family unit is very important, in respect to health and the welfare of a person, which also involves the extended family (Nwadiora, 1996). West African immigrant families’ belief system also has an effect on how mental health is defined. Families often rely on each other for guides. Family connectedness, interpersonal control, and communication styles that fall under the domain of family organization endure in various manifestations of West African immigrant life (Nwadiora, 1996). Family involvement is crucial to a healing process amongst West African immigrants. It is a support network, which can help cope with the psychosocial stressors in life. A West African immigrant family works together to overcome challenging obstacles; therefore, the need for cultural and family centered mental health services is important in helping a West African immigrant family member cope with a mental health illness.

The effect of stigma and its resultant social withdrawal may have a greater impact on an individual than the illness (Sherman, 2007). Family members are also harmed by stigma and may be blamed for causing or contributing to the illness (Sherman, 2007). Community attitudes can negatively affect recovery to a measurable extent.

In order to understand and describe mental illness stigma we distinguish public stigma from self-stigma. Public stigma occurs when members of the general public
endorse stereotypes and act on discriminatory behaviors such as refusing to hire someone because of mental illness. The self-stigma process initially includes self-stereotypes which individuals become aware of the socially endorsed stereotype, e.g., individuals with mental illness are too incompetent or unpredictable to hold responsible jobs. The second step is comprised of self-prejudice in which individuals agree with the stereotypes. The third stage is self-discrimination in which individuals apply the stereotype to themselves, e.g., I must be too incompetent, and I’m not going to look for work (Larson & Corrigan, 2008).

Family stigma contains the stereotype of blame, shame, and contamination; public attitudes that blame family members for incompetence may conjure the onset or relapse of a family member’s mental illness. Typically, blame is attributed to poor parenting skills that led to a child’s mental illness. Within the medical field, biological and genetic models have replaced the notion that bad parenting causes mental illness; however, the general public still attributes poor parenting as a cause of mental illness (Larson & Corrigan, 2008).

In conclusion, assumptions are made with respect to mental health among West African immigrants such as the lack of utilization of services due to lack of mental health understanding or stigma (Larson & Corrigan, 2008; Lu, 2003). However, many aspects are not taken into consideration such as barriers and cultural dynamics. Many West African immigrants are not eligible for services due to their illegal status in this country and Health insurance is far too expensive for West African immigrants to purchase.
(MacLachlan, 1997; Purnell & Paulanka, 2003). Lack of bilingual and bicultural professionals create cultural and language barriers and thus preventing West African immigrants from obtaining the proper mental health care (Spector, 1996). The lack of cultural knowledge among professionals and services often leaves West African immigrants who suffer from mental illness in the hands of the justice system, leading many West African immigrants to be incarcerated for symptoms of mental health illness. Low economy status and lack of health insurance are risk factors for immigrants to develop mental illness that could also leave them homeless or incarcerated without mental health treatment.

Many West African immigrants who suffer mental illness are at risk of being homeless. Due to the lack of research and cultural competence among professionals in mental health, West African immigrants might not benefit from a diagnosis treatment process (Rundle et al., 2002; Spector, 2000). If mental health professionals are not fluently bilingual the risk of West African immigrants for misdiagnosis is increased. Therefore, service providers are not addressing barriers that West African immigrants face. Often time’s West African immigrants are misunderstood.

Professionals and agencies in the field of mental health need to be aware of the socioeconomic, language, legal status and health literacy barriers that prevent West African immigrants from obtaining services. Mental health information, resources, and services delivery need to be culturally and linguistically sensitive in order to support and treat the West African immigrant population who are dealing with mental health illness.
With professionals and agencies being aware of the different perceptions and social factors that prevent West African immigrants from receiving mental health services, obstacles faced by this population will be diminished (Okafor, 2009; Thomas, 2008). The finding of this study will hopefully add to our understanding of whether or not these barriers continue to prevent utilization mental health of service by the West African immigrant population in Northern California.

Chapter 2 looked into the diversity of the American population with a growing number of minority groups that includes immigrants from West Africa. It also examined the feelings of minority clients towards professional counseling, and the new approach (multiculturalism) being emphasized as a way of meeting the needs of this increasingly diverse population. Furthermore, this chapter talked about how this new approach has led to the study of worldviews of minority groups in America such as African Americans, Asian Americans, Hispanic Americans, and Native Americans, but no major studies on the West African population. This has prompted this researcher to study the West African immigrant population to determine their attitudes towards mental health issues.

This chapter examined the roles economy, politics, and social conditions have played in the lives of West Africans before and after their migration. Reasons for West Africans’ presence in the United States were considered, as well as the experience of these West African immigrants especially as it concerns racism and discrimination, adjustment and socio-cultural issues. Furthermore, strategies for survival adopted by
West African immigrants and how they deal with their mental health issues were examined.

Finally, there was a review of studies done on a major instrument (ATSPPH) used in measuring the attitudes of various minority groups towards seeking professional psychological help, which this researcher intends to use with a West African immigrant population.

If conclusions from the aforementioned studies on immigrants and ethnic minorities are valid, then it seems likely that West African immigrants in the U.S. may perceive the outcome of seeking help for psychological issues negatively given that psychological problems are viewed negatively in their culture, and therefore there may be a higher social stigma attached to seeking help for their psychological problems. This tendency to protect and isolate psychological problems may hinder West African immigrants from accessing services that could potentially help them. Thus, this study will also focus on the variable of problem attribution.
Chapter 3

METHODOLOGY

There has been little research done on mental health among the West African immigrant population in the United States. The purpose of this study was to capture the meaning of mental health among West African immigrant eliciting the subjective knowledge of the West African immigrant population in Northern California. This exploratory study investigates the broad cultural view of West African immigrants residing in Northern California, and their attitudes toward seeking Mental Health Services. This study explored the difficulties, challenges, and obstacles facing West African immigrants in seeking mental health services in mainstream American culture. This chapter outlines the various procedures used to collect and analyze data for each of the research questions. It consists of a study questions, design of the study, study sample participant selection, instruments, procedure, data collection, protection of human subjects, and explanation of implied consent, and questionnaire administration.

Study Questions

RQ1: Are West African immigrants in Northern California open and comfortable in admitting they have mental, emotional, and behavioral problems?

RQ2: Are they open and comfortable with seeking mental health services from qualified Professionals in Northern California?

RQ3: What factors (education, economy, acculturation, access to information) influence the Immigrants’ attitudes towards seeking mental health services?
Research Design

Due to limited research, and limited knowledge about the different cultural values and attitudes of West African immigrant the exploratory design was used in this particular project. There is a problem in the lack of existing, culturally sensitive and culturally appropriate educational resources. A variety of factors, both on the part of the mental health professional and the mental health consumers could be identified. The Literature review for this project also explores how the concept of mental health, cultural values, and beliefs has influenced West African immigrants’ attitudes in seeking mental health utilization. This information was gathered in order to assist mental health and social service professionals with a better understanding of West African, immigrants in context, and not as separate from their culture, family, and community.

Sampling

This study was conducted by means of mixed methods and multisource design such as convenience sample and snowball. For that reason this was convenience non-probability purposive sampling with elements of snowball sampling, because when the researcher approached individuals who were willing to participate in the study, referrals to other eligible subjects who might be willing to participate in the study were requested. The researcher expected to get a representative sample of the group using membership lists from known organizations of West African immigrants here in Northern California. This sample included immigrants from multiple countries in West Africa. Only West African immigrants residing in Northern California were eligible to participate in this
research; all other individuals were excluded. The researcher sent questionnaires to individuals as well as established organizations. The researcher solicited the help of the presidents, secretaries, and publicity secretaries of said organizations to pass the questionnaires to individual members for their individual response. Participation in this research for all respondents was voluntary; there was no quid pro quo of any kind or shape from the researcher or her designee. In order to avoid any conflict of interest, no relatives or friends of the researcher were involved. Respondents were not asked to supply their name on the survey. Additional community participants were recruited through the “snowball” method, in which an individual who had already agreed to participate in the study referred another individual to the researcher.

Participants

It was the hope of the researcher to obtain 300 participants for this research study. But, this number was changed due to the exorbitant amount of money it was going to cost the researcher. The researcher was able to send out one hundred and eighty-two questionnaires to West African immigrants residing in Northern California, who had to be at least must eighteen years or older to participate. Prospective participants were West African immigrants from countries such as Benin, Burkina Faso, Ivory Coast, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and Togo who now reside in Northern California. The researcher received 116 completed questionnaires.
Instruments

The researcher has adapted the *Attitude Toward Seeking Professional Psychological Help Scale* (ATSPPHS) (Fischer & Turner, 1970), a widely used instrument for conceptualization of help-seeking attitudes in both the USA and other countries, to use in the research. This scale was developed by Fischer and Turner in 1970. ATSPPHS is a test instrument that measures an individual’s outlook on seeking psychological assistance. It consists of 30 items designed to assess general attitudes toward seeking professional help for psychological problems and issues. This scale, ATSPPHS, was developed by the authors to clarify the assumption that there were specific attitudes and personality domains that might be related to one’s tendency to seek professional help. Fischer and Turner found four factors or subscales for the ATSPPH scale. The questionnaire has four subscales: Recognition of need for psychological help, stigma or tolerance concerns, interpersonal openness, and confidence in psychologists. Recognition of the need for psychological help comprises eight items assessing whether respondents think that psychological or emotional problems are issues that may demand professional attention. Stigma tolerance contains five items assessing the respondent’s ability to disregard the stigma associated with seeking help for psychological or emotional problems. Interpersonal openness consists of seven items assessing respondents’ willingness to disclose their problems with professional helpers. Confidence in psychologists consists of nine items assessing whether respondents believe that psychologists or counselors can help with their
problems. Knowledge of available services is a single item asking respondents if they know how and where to get help in case they need to. Preference of ethnically similar helpers is a single item question asking whether the ethnic background of professional helpers is an important factor when seeking professional help. Items are rated using a 4-point Likert type scale ranging from (O) disagree to (3) agree. Eleven items are positively keyed so that agreement indicates positive attitudes, and 18 are negatively keyed so that disagreement with the item shows positive attitudes toward seeking psychological help. The ATSPPHS is a widely used instrument across the globe, and has been found to be a reliable measurement.

The ATSPPH scale has been shown to have good internal consistency when used amongst Westerners, and across the globe. The demographic section used for the purpose of the research was developed by Thomas (2006). This section distinguished between respondents from different countries with different demographic characteristics. While all participants are West African immigrants, the researcher anticipated that the sub-categories such as income and education levels, as well as length of residence in their adopted country, would significantly influence the attitudes of the respondents.

Procedure

The research recruited the participants from known individuals, and from member lists of different West African organizations in Northern California. These organizations gave their permission for the use of their member lists. The researcher sent out the questionnaire, and included self-addressed stamped envelopes for their convenience. In
addition, the researcher used a snowball sample of West African individuals identified by the researcher to include participants who are not members of these organizations. Survey questionnaires were sent on December 27, 2009 through January 11, 2010, and data collection was concluded February 5, 2010.

Data Collection

Written instructions and consent to participate as a research subject form, as opposed to formal consent letter, were attached to each questionnaire identifying the researcher, and explaining the purpose of the study; guidelines on how to answer the questionnaire, and amount of time it would take to complete the instrument. The prospective participants were given assurance that their participation in this survey was strictly voluntary, and every step would be taken to protect their privacy. The instruments were constructed in such a manner that there was no place for the participant to sign to avoid any chance of a participant writing their name. Identifying personal information was eliminated from the survey questionnaires. According to the Protection of Human Subject used for research, no information was requested that would identify a particular participant. Lastly, the researcher made a reminder phone call to each prospective participant. One hundred and sixteen (64%) completed questionnaires were returned out of the one hundred and eighty-two that were sent out, twenty-two were returned due to insufficient addresses, some were only partially completed, and some did not come back.

The author used an instrument developed by Fischer and Turner (1970) titled Orientations to Seeking Professional Psychological Help: Development and research
utility of an attitude scale. Section one: West African immigrants and their attitudes towards seeking mental health services. The primary purpose of the survey instrument was to generate information that would provide a better understanding of the cultural attitudes that West African immigrants have regarding their attitudes toward seeking mental health services. Thirty questions were answered using a Likert-scale ranging from strongly agree (SA), agree (A), to disagree (DA), and strongly disagree (SDA). This section encompasses a wide-array of issues ranging from a philosophical conception of mental health services, to issues involving attitudes towards seeking psychological help.

Section two: Demographics. The final section elicits demographic data. Sixteen demographic questions were included in the questionnaire. Questions were related to educational level, country of origin, number of children, income level, and length of residence in the United States. The goal is that their responses would help to identify the fundamental issues confronting West African immigrants as they seek mental health services in the mainstream culture. This demographic section used for the purpose of the research was developed by Thomas (2006). He originally used it for his Doctoral dissertation titled, *West African Immigrants’ Attitudes towards Seeking Psychological Help* (See Appendix B for the complete questionnaire).

Protection of Human Subjects

The researcher developed the Human Subject Protocol form and submitted it to the Project Advisor, Dr. Susan Taylor. Dr. Taylor approved the form, and it was then submitted to the Committee for the Protection of Human Subjects in the Division of
Social Work. The committee approved the Human Subject Protection form. The approval number is: 09-10-060.

The researcher made the following necessary changes before the Human Subject form was approved:

- An explanation of why implied consent was used
- Explicitly stating that the study poses Minimal risk
- Stating the right of participants to withdraw at any time
- A description of how data will be stored and disposed of

After the form was approved, the researcher began to collect the data and distributed surveys to the participants.

Explanation of Implied Consent

The reasons behind the use of implied consent is to keep each participant’s name, address, and phone number out of the research consent form, as participants sometimes unconsciously put their names instead of their required signature. To avoid any mistakes, or ambiguity, this researcher believes it is necessary to completely eliminate anything that will identify the research participants in the form of their name, address, phone number, or signature.

The participants were received the consent letter without a designated spot for the information mentioned. In effect, returning the survey questions signified that participants have consented to participate in the research study. The study was approved as minimal risk. To ensure the protection of the participants’ confidentiality, privacy, and
safety the researcher informed the participants that their participation was completely voluntary in their official language. All data and implied consent forms were kept confidential in a locked cabinet located in a secure area that only this researcher has access to. All data and implied consent forms were destroyed when the project was finished. Participants were provided with counseling resources including names, addresses, and phones numbers where they could access services should they experience discomfort. Data analysis and presentation of information was to ensure that the information was presented in a scientific way without any possibility of identifying any individual. Only collective themes and a summary of findings were presented.
Chapter 4

ANALYSIS OF DATA

Introduction

This chapter presents the study findings and discusses the relevance of the findings in the context of the study questions and the themes that were discussed in the literature review. This study was completed for the purpose of acquiring knowledge about West African immigrants’ perception of mental health and services utilization in Northern California. This study is aimed to create a better understanding of how West African immigrants define mental health, and to provide information on mental health services that are offered in their community. This chapter presents the analysis and the findings of in this exploratory study. One hundred and 16 subjects participated in the study by responding to a questionnaire (see Appendix B). The data is summarized, and relevant findings are listed as tables and charts primarily through descriptive statistics and frequency distributions.

Socio-Demographics

The data collected from the questionnaires were coded and entered into the SPSS statistical Package Social Science program for analysis. Survey questionnaires were completed by 59 (50.9%) female respondents and 57 (49.1%) male respondents. Figure 4 presents data on respondents’ gender.
Figure 4. Gender distribution of the respondents.

Table 1 indicates the demographic profile of the respondents’ age. The average of all the respondents is 45, and standard deviation is 10.05. The average numbers of years stayed in United States is 16 years and the standard deviation is 10.05. The average age of all the respondents at the time when immigrated to United States is 27 years and Standard deviation is 8.7. The average family size of the respondents is four and standard deviation is 1.9. The average number of respondents’ relatives in the United States is six and standard deviation is six.
Table 1

Demographic Profile of the Respondents

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of relatives</td>
<td>76</td>
<td>.00</td>
<td>30.00</td>
<td>6.2105</td>
<td>6.01180</td>
</tr>
<tr>
<td>Age</td>
<td>115</td>
<td>18.00</td>
<td>72.00</td>
<td>45.2783</td>
<td>10.05297</td>
</tr>
<tr>
<td>Years in US</td>
<td>113</td>
<td>1.00</td>
<td>44</td>
<td>16.56</td>
<td>10.051</td>
</tr>
<tr>
<td>Family size</td>
<td>110</td>
<td>1.00</td>
<td>15.00</td>
<td>4.5364</td>
<td>1.98470</td>
</tr>
<tr>
<td>Age when immigrated to US</td>
<td>113</td>
<td>11.00</td>
<td>58.00</td>
<td>27.9558</td>
<td>8.73457</td>
</tr>
<tr>
<td>Valid N (list wise)</td>
<td>69</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 5. Demographics city of respondents.

Figure 5 indicates the cities respondents are residing in Northern California. Sixty-three respondents of the population come from Sacramento (54.3%), 18 of those respondents from Elk Grove (15.5%) and nine of the respondents from San Jose (7.8%). While three of the respondents from Stockton (2.6%), two evenly from the cities of Antioch and Lincoln (1.7%), one respondent from each of the rest of cities not mentioned (.9%).
<table>
<thead>
<tr>
<th>Contact for Health</th>
<th>Gender</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>Count</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>5.4%</td>
<td>5.5%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>Count</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>1.8%</td>
<td>3.6%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Social worker</td>
<td>Count</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>0.0%</td>
<td>1.8%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Counselor</td>
<td>Count</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>3.6%</td>
<td>7.3%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Minister/Clergy</td>
<td>Count</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>10.7%</td>
<td>5.5%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Spiritual Healer</td>
<td>Count</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>3.6%</td>
<td>1.8%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Friends</td>
<td>Count</td>
<td>17</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>30.4%</td>
<td>16.4%</td>
<td>23.4%</td>
</tr>
<tr>
<td>Family member</td>
<td>Count</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>5.4%</td>
<td>10.9%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Medical Doctor</td>
<td>Count</td>
<td>18</td>
<td>23</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>32.1%</td>
<td>41.8%</td>
<td>36.9%</td>
</tr>
<tr>
<td>Other</td>
<td>Count</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>7.1%</td>
<td>5.5%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>56</td>
<td>55</td>
<td>111</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Table 2 illustrates the contact that respondents will make to address their health concerns with gender. Most respondents (36.9%) go to the medical doctor to seek psychological help. While (23.4%) of the respondents go to friends for psychological help; surprisingly, only 0.9% of the respondents seek psychological help from a social worker.

Figure 6. The cross tabulation respondents’ household income and higher education level.

Figure 6 illustrates the correlation between education and household income. Respondents’ total household incomes before taxes or any other deductions included those respondents were under $10,000 were high school diploma; $20,000-$29,9999
were associate/2 year degree; $30,000-$39,999 were some college; $40,000-$49,999 were bachelor/4 years; $50,000-$59,999 were some graduate/professional; $60,000-$69,999 were graduate or professional; $70,000 or more earn the same of graduates depending on the discipline. The conclusion the author of this study has drawn is the more education respondents have the higher their annual income.

As Table 3 presents various household income categories of by language competency. As indicated below, 47% of respondents have a total household income of $70,000 and more and most of them speak English extremely well (52%). The lowest categories of respondents (0.9%) have a total household income of fewer than 10,000, only (1%). Of the respondents that have the lowest household income speak English extremely well. This indicates that West African immigrants who speak English will tend to receive highest household income than those who do not speak English well.
Table 3

**Total Household Income and English Language Proficiency Cross Tabulation**

<table>
<thead>
<tr>
<th>Total Household Income</th>
<th>Count</th>
<th>% within English Language</th>
<th>English Language</th>
<th>Quite a bit</th>
<th>Extremely well</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $10,000</td>
<td>0</td>
<td>.0%</td>
<td>Moderate</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>$20,000-$29,999</td>
<td>1</td>
<td>25.0%</td>
<td>Quite a bit</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>$30,000-$39,999</td>
<td>1</td>
<td>25.0%</td>
<td>Extremely well</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>$40,000-$49,999</td>
<td>1</td>
<td>25.0%</td>
<td></td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>$50,000-$59,999</td>
<td>1</td>
<td>25.0%</td>
<td></td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>$60,000-$69,999</td>
<td>1</td>
<td>25.0%</td>
<td></td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>$70,000 &amp; More</td>
<td>1</td>
<td>25.0%</td>
<td></td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>100.0%</td>
<td></td>
<td>9</td>
<td>102</td>
<td>115</td>
</tr>
</tbody>
</table>

% within English Language
Table 4

*Country of Origin of the Respondents*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana</td>
<td>3</td>
<td>2.6</td>
<td>2.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Liberia</td>
<td>27</td>
<td>23.3</td>
<td>23.3</td>
<td>25.9</td>
</tr>
<tr>
<td>Niger</td>
<td>1</td>
<td>.9</td>
<td>.9</td>
<td>26.7</td>
</tr>
<tr>
<td>Nigeria</td>
<td>77</td>
<td>66.4</td>
<td>66.4</td>
<td>93.1</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>7</td>
<td>6.0</td>
<td>6.0</td>
<td>99.1</td>
</tr>
<tr>
<td>Togo</td>
<td>1</td>
<td>.9</td>
<td>.9</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>116</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

As the Table 4 indicates, seventy-seven of respondents come from Nigeria (66.4%), 27 of the respondents from Liberia (23.3%), and seven of the respondents from Sierra Leone (6.0%). While three of the respondents from Ghana (2.6%) and one of respondents even comes from these two countries Togo and Niger (.9%). There were no respondents from these countries of West Africa, such as Ivory Coast, Mauritania, Mali, Gambia, Burkina Faso, and Benin. Perhaps lack of organizations and researcher was unable to connect with the some of the other West African organizations in Northern California.
Table 5

*Higher Education level and confidence in finding relief in psychotherapy when experiencing emotional crisis*

<table>
<thead>
<tr>
<th>Higher Education level</th>
<th>Partly Agree</th>
<th>Partly Disagree</th>
<th>Totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School Diploma</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Associate/two year degree</td>
<td>6</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Some college</td>
<td>6</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Bachelors or four years</td>
<td>12</td>
<td>11</td>
<td>34</td>
</tr>
<tr>
<td>Some graduate/professional</td>
<td>7</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Graduate or professional</td>
<td>13</td>
<td>14</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>36</td>
<td>116</td>
</tr>
</tbody>
</table>
Table 5 presents the results of cross tabulation of confidence in finding relief in psychotherapy when experiencing emotional crisis and educational level of respondents. Of all the respondents with only a high school diploma, one finds confidence in finding relief in psychotherapy when experiencing emotional crisis. Of all the respondents with graduate or professional degree 40 of them have confidence in finding relief in psychotherapy when experiencing emotional crisis. This demonstrated that the West African immigrants level of education play vital role in attitudes in seeking mental health service.

Table 6

Cross tabulation of respondents education level and their attitudes of being ashamed of mental illness

<table>
<thead>
<tr>
<th>Attitude of being ashamed of mental illness</th>
<th>Agree</th>
<th>Partly Agree</th>
<th>Partly Disagree</th>
<th>Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>% within Higher Education level</td>
<td>50.0%</td>
<td>9.1%</td>
<td>8.2%</td>
<td>50.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Count</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>% within Higher Education level</td>
<td>27.3%</td>
<td>9.1%</td>
<td>8.2%</td>
<td>27.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Count</td>
<td>5</td>
<td>10</td>
<td>2</td>
<td>34</td>
<td>4</td>
</tr>
<tr>
<td>% within Higher Education level</td>
<td>32.4%</td>
<td>29.4%</td>
<td>3.1%</td>
<td>37.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Count</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>40</td>
<td>6</td>
</tr>
<tr>
<td>% within Higher Education level</td>
<td>31.2%</td>
<td>25.0%</td>
<td>.2%</td>
<td>35.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Count</td>
<td>9</td>
<td>12</td>
<td>5</td>
<td>116</td>
<td>8</td>
</tr>
<tr>
<td>% within Higher Education level</td>
<td>22.5%</td>
<td>25.0%</td>
<td>12.5%</td>
<td>35.3%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
In Table 6 categories are organized by education level beginning with the category 3 being those who have obtained a high school diploma and culminating in category 8 being those who have completed a graduate education. As the table indicates, 50% of those respondents who have only a high school diploma (represented by number 3) agree with the statement that being mentally ill carries with it a burden of shame.

Assessing Attitudes of Seeking Mental Health Services

Research question one sought to investigate a broad range of attitudes toward seeking mental health services amongst West African immigrants residing in Northern California. For example, table 15 indicates that the largest groups of survey respondents (39.7%) believe that clinics have the ability to treat emotional and personal problems, and therefore, they may be willing to seek their services. The twenty respondents (17.2%) partly disagree with the statement that they have no faith in the ability of clinics to solve personal or emotional problems. The smallest group of survey respondents (16.4%) agrees with the concept that clinics are not helpful in treating emotional or personal problems, and 31 respondents (26.7%) partly agree with the statement (see Table 7).
Table 7

*Lack of faith in clinic’s ability to solve personal problems*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>19</td>
<td>16.4</td>
<td>16.4</td>
<td>16.4</td>
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<tr>
<td>Partly Agree</td>
<td>31</td>
<td>26.7</td>
<td>26.7</td>
<td>43.1</td>
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<tr>
<td>Partly Disagree</td>
<td>20</td>
<td>17.2</td>
<td>17.2</td>
<td>60.3</td>
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<tr>
<td>Disagree</td>
<td>46</td>
<td>39.7</td>
<td>39.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 8

*Attitude on whether to recommend that a friend see a counselor*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>61</td>
<td>52.6</td>
<td>53.0</td>
<td>53.0</td>
</tr>
<tr>
<td>Partly Agree</td>
<td>33</td>
<td>28.4</td>
<td>28.7</td>
<td>81.7</td>
</tr>
<tr>
<td>Partly Disagree</td>
<td>9</td>
<td>7.8</td>
<td>7.8</td>
<td>89.6</td>
</tr>
<tr>
<td>Disagree</td>
<td>12</td>
<td>10.3</td>
<td>10.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td>99.1</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>System</td>
<td>1</td>
<td>.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 8 shows that the majority of respondents (52.6%) agreed that they would recommend that their friend see a counselor. The next largest group (28.4%) partly agreed that they would recommend that their friend see a counselor when having some kind of problem. Only nine of the respondents (7.8%) partly disagree, and 10.3% of the respondents would not recommend that their friend see a counselor. One did not indicate their choice.

Table 9

*Feel Uneasy Going to see a Counselor*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Agree</td>
<td>17</td>
<td>14.7</td>
<td>14.7</td>
<td>14.7</td>
</tr>
<tr>
<td>Partly Agree</td>
<td>29</td>
<td>25.0</td>
<td>25.0</td>
<td>39.7</td>
</tr>
<tr>
<td>Partly Disagree</td>
<td>19</td>
<td>16.4</td>
<td>16.4</td>
<td>56.0</td>
</tr>
<tr>
<td>Disagree</td>
<td>51</td>
<td>44.0</td>
<td>44.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>116</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

The smallest group of respondents (14.7%) agreed that they would feel uncomfortable going to see a counselor. Twenty-five percent partly agreed that seeing a counselor would make them feel uneasy. Nineteen of the respondents (16.4%) were not totally against seeking a counselor. The largest group of respondents (44%) reported that they would see a counselor despite what people might think about them.
Table 10

Respondents’ Perception of Strength of Character and Overcoming Mental Conflict Without Assistance

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>21</td>
<td>18.1</td>
<td>18.1</td>
<td>18.1</td>
</tr>
<tr>
<td>Partly Agree</td>
<td>24</td>
<td>20.7</td>
<td>20.7</td>
<td>38.8</td>
</tr>
<tr>
<td>Partly Disagree</td>
<td>26</td>
<td>22.4</td>
<td>22.4</td>
<td>61.2</td>
</tr>
<tr>
<td>Disagree</td>
<td>45</td>
<td>38.8</td>
<td>38.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 10 exhibits respondents’ view of whether counseling is as effective as a strong character. Thirty-nine percent of survey participants disagree with the statement that a person with a strong character can overcome mental conflicts by himself or herself. Another 22.4% of respondents partly disagree with the statement. Twenty percent of the respondents partly agreed with the statement, and 18.1% of respondents agree with the statement that a person with a strong character can overcome mental conflict by himself or herself and therefore has no need for a counselor.
Table 11

Respondents’ Perceptions of Receptivity to Professional Advice when Feeling Lost

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>42</td>
<td>36.2</td>
<td>36.2</td>
<td>36.2</td>
</tr>
<tr>
<td>Partly Agree</td>
<td>30</td>
<td>25.9</td>
<td>25.9</td>
<td>62.1</td>
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<tr>
<td>Partly Disagree</td>
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<td>8.6</td>
<td>8.6</td>
<td>70.7</td>
</tr>
<tr>
<td>Disagree</td>
<td>34</td>
<td>29.3</td>
<td>29.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 11 illustrates that 36.2% of survey respondents agree with the statement that they would seek professional advice when feeling lost due to a personal or emotional problem. Another 25.9% of respondents partly agreed with the statement, meaning that they might seek professional advice when feeling lost due to personal or emotional problems. Table 4.11 indicates that 29.3% of the respondents disagree with the statement that there are times when he/she have felt completely lost and would have welcomed professional advice. Whereas 8.6% of respondents partly disagree, suggesting that they would probably not seek professional advice to solve their problem.
Table 12

Willingness to get psychological help

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>9</td>
<td>7.8</td>
<td>7.8</td>
<td>7.8</td>
</tr>
<tr>
<td>Partly Agree</td>
<td>15</td>
<td>12.9</td>
<td>12.9</td>
<td>20.7</td>
</tr>
<tr>
<td>Partly Disagree</td>
<td>20</td>
<td>17.2</td>
<td>17.2</td>
<td>37.9</td>
</tr>
<tr>
<td>Disagree</td>
<td>72</td>
<td>62.1</td>
<td>62.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 12 shows the respondents’ responses to whether they would rather live with certain mental conflicts than go through the ordeal of getting psychological help. The majority of the respondents (62.1%) disagree with the statement, and 17.2% of the respondents partly disagree. On the other hand, 12.9% partly agreed while only 7.8% agreed with the statement.
Table 13

*Attitude on discussing problems with immediate family*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>59</td>
<td>50.9</td>
<td>51.3</td>
<td>51.3</td>
</tr>
<tr>
<td>Partly Agree</td>
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<td>77.4</td>
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<tr>
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<td>7.0</td>
<td>84.3</td>
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<tr>
<td>Disagree</td>
<td>18</td>
<td>15.5</td>
<td>15.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
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<td>100.0</td>
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<td>.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As Table 13 illustrates the majority of the respondents (50.9%) agree that there are certain problems that should not be discussed outside of one’s immediate family and 25.9% of the respondents partly agree with that statement. Of the other respondents 15.5% disagree while 6.9% partly disagree with the notion that certain problems should only be discussed within the immediate family.
Table 14

*Attitude on Being Secure in Good Inpatient Psychiatric Unit*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valid</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>59</td>
<td>50.9</td>
<td>50.9</td>
<td>50.9</td>
</tr>
<tr>
<td>Partly Agree</td>
<td>25</td>
<td>21.6</td>
<td>21.6</td>
<td>72.4</td>
</tr>
<tr>
<td>Partly Disagree</td>
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<td>17.2</td>
<td>17.2</td>
<td>89.7</td>
</tr>
<tr>
<td>Disagree</td>
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<td>10.3</td>
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<tr>
<td><strong>Total</strong></td>
<td>116</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 14 indicates that the majority of the respondents (50.9%) agree with the statement that a person with a serious emotional disturbance would probably feel most secure in a good inpatient psychiatric unit. The next largest group of respondents (21.6%) partly agrees with the statement, though that does not necessarily mean they accepted the concept. A smaller of respondents (10.3%) disagreed with the statement whereas 17.2% partly disagreed with the statement that a person with serious emotional disturbance would probably feel most secure in a good inpatient psychiatric unit.
Table 15

*Attitude on Being Secure in Good Inpatient Counseling Unit*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>55</td>
<td>47.4</td>
<td>47.4</td>
<td>47.4</td>
</tr>
<tr>
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<td>36</td>
<td>31.0</td>
<td>31.0</td>
<td>78.4</td>
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<tr>
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<td>12.1</td>
<td>12.1</td>
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<td>Disagree</td>
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<td>9.5</td>
<td>9.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
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<td></td>
</tr>
</tbody>
</table>

Table 15 demonstrates that 55 (47.4%) of the respondents agreed that a person with a serious emotional disturbance would probably feel most secure in a good inpatient counseling unit, 36 (31.0%) partly agreed while 14 (12.1%) partly disagreed. Of the 116 respondents, only 11 (9.5%) disagreed that there a person with a serious emotional disturbance would probably feel most secure in a good counseling unit.
Table 16

*Belief in Seeking Professional Help When Having a Mental Breakdown*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>60</td>
<td>51.7</td>
<td>52.2</td>
<td>52.2</td>
</tr>
<tr>
<td>Partly Agree</td>
<td>32</td>
<td>27.6</td>
<td>27.8</td>
<td>80.0</td>
</tr>
<tr>
<td>Partly Disagree</td>
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<td>12.2</td>
<td>92.2</td>
</tr>
<tr>
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<td>7.8</td>
<td>7.8</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td>99.1</td>
<td>100.0</td>
<td></td>
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<tr>
<td><strong>Missing</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>System</td>
<td>1</td>
<td>.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>116</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 16 demonstrates that a majority of respondents (51.7%) agreed that if they were having a mental breakdown their first inclination would be to get professional attention; 32 (27.6%) partly agreed. Fourteen respondents (12.1%) partly disagreed, and nine (7.8%) disagreed with the idea that one should seek professional help when having a mental breakdown.
Table 17

*Attitude on Having Friends as Advisors Rather than a Psychologist*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
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<td>Agree</td>
<td>22</td>
<td>19.0</td>
<td>19.0</td>
<td>19.0</td>
</tr>
<tr>
<td>Partly Agree</td>
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<td>21.6</td>
<td>21.6</td>
<td>40.5</td>
</tr>
<tr>
<td>Partly Disagree</td>
<td>24</td>
<td>20.7</td>
<td>20.7</td>
<td>61.2</td>
</tr>
<tr>
<td>Disagree</td>
<td>45</td>
<td>38.8</td>
<td>38.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

As indicated on Table 17, when asked would you rather be advised by a close friend than by a psychologist, even for an emotional problem, 22 respondents agreed (19.0%), 25 partly agreed (21.6%), 24 partly disagreed (20.7%), and 45 disagreed (38.8%).
Table 18

*Attitude on Resenting a Person who wants to know about my Personal Difficulties*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
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<td>13.9</td>
<td>13.9</td>
</tr>
<tr>
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<td>20.0</td>
<td>33.9</td>
</tr>
<tr>
<td>Partly Disagree</td>
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<td>46.1</td>
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<tr>
<td>Total</td>
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<td>100.0</td>
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<tr>
<td>C Missing</td>
<td>System</td>
<td>1</td>
<td>.9</td>
<td></td>
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<tr>
<td>Total</td>
<td>116</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 18 highlights that 16 of the respondents (13.8%) agreed they would feel resentful towards a trained professional who questioned them about their personal difficulties, and 23 of those (19.8%) partly agreed. Twenty-three of respondents partly disagreed (19.8%). Of the 116 respondents, 53 disagreed (45.7 %) on the above statement, and of the 116 respondents, nearly half (53) disagreed with the statement, and 23 (19.8%) partly disagreed that they would resent sharing personal information with a professional.
Table 19

*Respondents’ Attitude of being Ashamed of Mental Illness*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
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</tr>
<tr>
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<td>32</td>
<td>27.6</td>
<td>27.6</td>
<td>27.6</td>
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<tr>
<td>Partly Agree</td>
<td>30</td>
<td>25.9</td>
<td>25.9</td>
<td>53.4</td>
</tr>
<tr>
<td>Partly Disagree</td>
<td>13</td>
<td>11.2</td>
<td>11.2</td>
<td>64.7</td>
</tr>
<tr>
<td>Disagree</td>
<td>41</td>
<td>35.3</td>
<td>35.3</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>116</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
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</tbody>
</table>

Table 19 indicates the respondents’ thoughts about mental illness. Thirty-two (27.6%) of the respondents agreed that being mentally ill carries with it a burden of shame, 30 (25.9%), partly agreed with the statement, while 13 partly disagreed (11.2%). Of the 116 respondents, the largest number, 41, (35.3%) disagreed that being mentally ill carries with it a burden of shame.
Table 20

*Attitude on Knowing Everything about Oneself*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>18</td>
<td>15.5</td>
<td>15.5</td>
<td>15.5</td>
</tr>
<tr>
<td>Partly Agree</td>
<td>27</td>
<td>23.3</td>
<td>23.3</td>
<td>38.8</td>
</tr>
<tr>
<td>Partly Disagree</td>
<td>15</td>
<td>12.9</td>
<td>12.9</td>
<td>51.7</td>
</tr>
<tr>
<td>Disagree</td>
<td>56</td>
<td>48.3</td>
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<tr>
<td>Total</td>
<td>116</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

As Table 20 indicates, 18 (15.5%) of the respondents agreed that it is probably best not to know everything about oneself, 27 (23.3%) of the respondents partly agreed whereas 15 of the respondents partly disagreed with the statement (12.9%). Nearly half of the 116 respondents, 56, disagreed with the statement; they believe that it is best to know as much as they possibly can about themselves.
Table 21

*Willingness to get Psychological Help if Worried or Upset for a Long Time*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>Agree</td>
<td>32</td>
<td>27.6</td>
<td>27.6</td>
</tr>
<tr>
<td></td>
<td>Partly Agree</td>
<td>45</td>
<td>38.8</td>
<td>66.4</td>
</tr>
<tr>
<td></td>
<td>Partly Disagree</td>
<td>16</td>
<td>13.8</td>
<td>80.2</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>23</td>
<td>19.8</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>116</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As Table 21 indicates that 32 (27.6%) of the respondents agreed with the idea that talking about problems with a psychologist strikes them as the best way to go; 45 partly agreed with the statement. Whereas 16 of the respondents partly disagreed, 23 disagreed that the best way to solve problems is talking to a psychologist.
Table 22

*Confidence in Finding Relief in Psychotherapy when Experiencing an Emotional Crisis*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
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<tr>
<td>Valid</td>
<td>116</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
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<tr>
<td>Agree</td>
<td>45</td>
<td>38.8</td>
<td>38.8</td>
<td>38.8</td>
</tr>
<tr>
<td>Partly Agree</td>
<td>36</td>
<td>31.0</td>
<td>31.0</td>
<td>69.8</td>
</tr>
<tr>
<td>Partly Disagree</td>
<td>22</td>
<td>19.0</td>
<td>19.0</td>
<td>88.8</td>
</tr>
<tr>
<td>Disagree</td>
<td>13</td>
<td>11.2</td>
<td>11.2</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 22 indicates that 45 (38.8%) of the respondents believed that they would find relief in psychotherapy when experiencing emotional crisis and 36 (31.0%) partly agreed with the statement. While 22 of the respondents partly disagreed (19.0%), 13 of the respondent disagreed (11.2%) meaning they do not have confidence in finding relief in psychotherapy when experiencing and emotional crisis.
Chapter 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

In conclusion, an extensive literature review reveals that West African immigrants are one of the most rapidly growing ethnic groups in the United States of America, and their population in northern California continues to grow. Research also revealed that West African immigrants have the lowest help-seeking statistics in the mental health system due to various factors. Mental health services for this group is one of many services that need to be looked into, and tailored to meet their needs. In sum, to understand the mental health issues of African immigrants in America, it seems important to first gain an understanding of the life experiences of African immigrant families in the U.S.

In this project, the first section of the literature review focused on West African immigration history, traditional values of African culture, the risk factors of developing mental health problems as immigrants struggle in the mainstream society, characters of help-seeking patterns, concepts of mental health issues, and the impact of their involvement in mental health treatments. The outcome of the literature review concluded that West African immigrants have higher vulnerabilities to develop mental health problems. However, the concepts of mental illness and stigmas attached to this illness led to low utilization rates of mental health services.
West African Immigrant Families

The family is the cornerstone of West African culture and consists of an extended family that includes one’s blood relatives from several generations. The African's identity is rooted in the community’s identity. Individuals are viewed as a part or an extension of the environment because of the belief that everything is functionally connected. Consequently, family plays an important role in the life experiences of West African immigrants to the U.S. Mental health is intricately intertwined with family dynamics. Family members can facilitate and provide care, report symptoms, and assist in decision-making. For immigrants, family involvement in mental health care may be more relevant or more important than it is for the general population. Family and extended family have been the strengths of West African immigrant culture. Thomas explains that the stress of immigration and living in a foreign culture may create stronger family ties and family dependence. Additionally, immigrant families may rely on family for functions that U.S born individuals typically handle without family involvement. In many cultures the needs of the family take precedence over individual needs.

When West African families arrive in the U.S., they face an abrupt change in social status. More specifically, they lose their identity as members of a majority group and must assume the identity of a minority group. Many West Africans have two or three jobs in order to survive economically in the U.S., while financially supporting their relatives in their native country. The stress incurred by family responsibilities impacts their psychological well being and may contribute to domestic disputes, child neglect,
and abuse. As a result, mental illness is often treated as a family matter, and mental health care decisions are usually made in the context of how they may impact on the family. In sum, to understand the mental health issues of West African immigrants in Northern California, it seems important to first gain an understanding of the life experiences of West African families in Northern California. The research indicated that West African immigrants attain high educational achievement in the United States, and there were correlations between the education attainment and higher income earnings.

Recommendations

Any professional working with West African immigrant families needs to adhere to some general principles that should be followed regardless of what specific therapeutic approach is used. In West African culture respect for elders and for the family name are held in high esteem. Ask your West African client how he or she wants to be addressed. Especially for the married woman or the man with a title, it is highly imperative to begin the initial sessions geared toward the major accomplishments of the family as a unit with a de-emphasis on the crisis. The therapist should first find out the history and intent of the family’s immigration to US. There should be windows of opportunity for the family and the therapist to discuss the family’s triumphs and tribulations in living in the U.S. If a couple has children, it is suggested that the therapist focus on the success of their children in school. The reason behind this style is we have to start from the strengths of the family and work towards the problem areas. Sometime some of the factors that cause marital discord include interference from the extended families in the country of origin, and the
expectation that immigrants must provide for them whether the couple have resources or not.

The author proposes use of an ethnographic model when interviewing clients so that the clients themselves become the practitioners’ cultural guides to learn about the other cultural world. As noted earlier, mental distress for many West African immigrants is expressed in terms of physical suffering. Consequently, therapists should discuss the mind-body connection with the African client and provide a rationale for using psychotherapy. The findings indicate that therapy is foreign for most Africans; self-disclosure to the therapist becomes easier once a trusting relationship is established. He explained further that because of the relation culture of Africans, they are more likely to respond to a therapist who is more active and personal and who shows dignity.

Implications for Social Work Practice

The professional social work is functional at three diverse levels: the micro, mezzo, and macro. This particular study would benefit not just the West African immigrant community but the knowledge of the West African immigrant community mental health services need, for example, perception of mental health services would help social workers to be mindfulness with other minority population as well. This study will also benefit social worker professionals by adding an understanding of cultural differences. A social will be equipped to effectively assess or evaluate a West Africans family without any preconceived idea about the family.
A social worker professional working with West African families should be aware of limited eye contact when interviewing. This less eye contact should not be misconstrued to hiding something. Apart from limited eye contact while conversing with West African immigrants, it is very highly imperative for social worker to pay special attention on West African communication pattern which is not explicit rather implicit. Their communication relies heavily on non-verbal commutation, facial expression, body positioning, and looking down base on the authority of the interactor. West African immigrants distrust or lack or distrust as displayed by the lack of eye contact may be inferred by the social worker and is one example of cultural differences. Furthermore, the social worker is an outsider and therefore considered an intruder in the family affairs, rather than mediator. Instead, it is preferable and cultural for family members to step in and mediate and counsel family members.

West African immigrants are culturally accommodative and highly receptive of others and other culture. It is therefore a recommendation of the author that social workers and the society at large should take advantage of this accommodation quality. Social workers must build confidence and rapport to gain family trust in order to provide service. It is a common cultural practice for West African immigrants to take family issues to the clergy, rather than governmental agencies. Such cultural practices should be exploited by the system for better understanding. If clergy are used it will lead to less traffic to the court and less burden on law enforcement.
The law enforcement should understand the cultural importance of remaining married in West African immigrant families. Marriage disagreements should not be always described as domestic violence. African immigrants are less like to involve law enforcement in their marital/domestic affairs. African immigrants are not argumentative with law enforcement; however, this does not translate to innocence or guilt. Because of their cultural norms with respecting authority, West African immigrants are less likely to argue or make eye contact with law enforcement. Sometime this behavior can be translated to guilt because the law enforcement officer does not know about the some of these cultural nuances of West African or the African immigrants at large. They are more inclined to plead and beg the law enforcement officer to overlook their issues hoping it will be taken care of without resulting to court action.

In addition, cultural competence integration in education setting is very highly imperative to acquire because the United States is multiethnic. This study touches a sensitive issue in the field of education. Cultural competence in education is required and important.” Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, among professional which enables that system, agency or those professionals to work effectively in cross-cultural situations. Understanding cultural competence means having the ability to function effectively in other cultural context or having and understanding and sensitivity to other cultures.
For teachers the author recommends an incorporation of many facets of cultural exposure in the curriculum, from field trips to cultural events in the community. Some of the various African cultural activities may include La Familia Festival a celebration of Mexican heritage, a celebration of Black History Month, the Chinese New Year or others, and field trips to the museums that exhibit various cultural artifacts such as the “Crocker Museum” in downtown Sacramento. Building on the value of diversity, the author recommends that teachers ask each of their students and families to come to the class and share their cultural heritage in the area of cultural artifacts, clothes, food, music, etc. Overall, the lack of cultural competencies could result in misconceptions and effect interactions with others.

Implications for Future Practice and Research

The rationale of this review was to provide an overview of the state of research on mental health issues of West African immigrants in Northern California. West African immigrants are at risk of developing mental health problems due to the unique stressors experienced during the various stages of the migration process. These stressors may include social isolation, acculturative stress, and family role changes. In some cases, these stressors may overcome African immigrant family's coping and adaptation, resulting in family conflict. In addition to family conflicts, family members, particularly African youth, experience unique life cycle issues that are affected by migration, issues that center largely on identity and family expectations from the country of origin. In addition, cultural beliefs influence how West African immigrants conceptualize what is
normal and abnormal behavior, the etiology and symptomatology of mental health problems, and what they consider appropriate mental health treatment. The most commonly observed mental health problems among West African immigrants include depression, anxiety, somatization, and PTSD. The recommended treatments for addressing these and other mental health concerns within the West African immigrant population, includes cognitive behavioral therapies, family therapy, and the use of psychotropic medications.

Practical Implications

Findings of this literature review embrace important practical implications for psychologists and other clinicians working with this population. Lately, immigrants from West Africa arrive in significant numbers, expanding the multicultural environment in Northern California. This implies that mental health service practitioners will be in increasing contact with the target population. It seems that West African immigrants will continue to play an increasingly important role in communities both in Northern California and across the U.S., thus stressing importance on addressing their mental health needs. Findings suggest that the U.S. mental health system may not be well equipped to meet the needs of racial and ethnic minority populations. Without culturally competent services, the failure to serve racial and ethnic minority groups adequately is expected to worsen, given the huge demographic growth in these populations predicted over the next decades. Culturally competent services incorporate respect for and understanding of, ethnic and racial groups, as well as their histories, traditions, beliefs,
and value systems. Practitioners should not become overwhelmed with the range of knowledge they must develop if they are to serve West African immigrants effectively.

Research Implications

The literature review found that there is limited research addressing mental health issues of African immigrants to the U.S. in the cross-cultural and psychological literature. The above review holds important research implications. There is a need for more researchers to conduct studies that can serve as a basis for advocacy for African immigrants. The findings suggested that there is a need for researchers to investigate how racism and stereotypes of African Americans impact the experiences of African immigrants. In particular, there is a need for research focusing on the beliefs and attitudes affecting African immigrants’ self-perceptions about race, ethnicity, and identity. Author, reported that the factors that promote and/or prevent trauma and stress are probably those that may heal the stressors of migration. Thus, researchers should study the early elements that seem to be associated with mental health, such as coping resources, self-identity, and esteem. West African immigrants to the U.S constitute a diverse group in terms of their immigration experiences, customs, traditions, and their approaches to mental health and illness.

Research is needed to better understand the impact of these differences on their mental health and their ability and willingness to access traditional Western care. Since there is a lack of adequate research with African immigrants, particularly in the area of mental health, significant issues that require attention include issues relating to thresholds
of psychological distress, attributions of mental illness to religious or supernatural forces, use of indigenous healing practices, levels of stigma attached to mental health problems, and help-seeking behaviors.

It is apparent that significant gaps exist in practitioners’ knowledge regarding the mental health issues and needs of African immigrants to the U.S. These gaps may be narrowed through additional training that would equip clinicians to address their African immigrant clients in a culturally sensitive manner, with an understanding of the many issues and barriers that may hinder their clients’ decision making or participation in the U.S. mental health system. Lastly, it is the hoped that the findings of this study contribute to de-stigmatizing mental health services and making the act of seeking treatment more culturally acceptable among the West African immigrants’ population in Northern California.
APPENDICES
TO: Florence Nwokocha  DATE: December 8, 2009

FROM: Committee for the Protection of Human Subjects

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, “West African Immigrants in Northern California and their Attitudes Towards Seeking Mental Health Services.”

__X_ approved as ____EXEMPT ____ NO RISK __ MINIMAL RISK.

Your human subjects approval number is: 09-10-060. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Teiahsha Bankhead, Chrys Barranti, Andy Bein, Joyce Burris, Maria Dinis, Susan Eggman, Serge Lee, Kisun Nam, Sue Taylor
Cc: Dr. Susan Taylor
APPENDIX B

Consent to Participate as a Research Subject

PROJECT TITLE: West African immigrants in Northern California and their Attitudes toward Seeking Mental Health Services

Dear Fellow West African Immigrants:

I am a graduate student at California State University, Sacramento. I am originally from Nigeria, and a graduate student in the department of Social work. I am conducting this research for my Masters of Social Work Degree (MSW), to study West African immigrants in Northern California and their attitudes toward seeking mental health services. It is my goal to learn more about the factors that influence the attitudes West African Immigrants hold about seeking mental health services, such as counseling, therapy and treatment. The results of this study will be used to further understand the attitude and experiences of West African immigrants residing in Northern California with regards to their attitudes toward seeking mental health services with the hope of helping our community take a different attitude towards mental health issues; thereby utilizing and taking advantage of the services available in our adopted home land.

Thank you very much for your participation in this study. The survey is in two parts. Please fill out this survey only if you are at least 18 years old and you are a West African immigrant currently living in Northern California. There is no consent form: returning the research package implies your consent to participate. Your responses and participation in this research are completely voluntary. Any information obtained in connection with this study will be reported in aggregate. The data will be summarized with no names, addresses, or phone numbers when reporting the results. Also, there will not be an identifying number on the survey itself. Questionnaires will be kept under lock and key and will be destroyed at the completion of the thesis. All results of the questionnaire will be reported in the aggregate. Please return the completed survey in the attached pre-paid stamped and addressed envelope. Please postmark by February 5, 2010, in order to be included in the data.

The minimum risk to your health and well-being related to your participation in this research will be limited to physical and psychological discomfort. Where this occurs as a result of the depth of the questions asked about seeking mental health services, you can take a break and continue later; or you can end your participation in this research study. Your participation is strictly voluntary. You may choose to withdraw at any time for any reason without penalty. If you wish, you may choose to pursue counseling or you may call a local mental health service provider or someone else of your choosing to discuss your feelings. A referral list of local mental health services is provided on the last page of the survey.

PARTICPANT INFORMATION SHEET
APPENDIX C

Participant Information Sheet and Research Questionnaires

If you have any questions about this research project, or concerns regarding this questionnaire, please contact me at (916) 230-3105 or email: Florenw7290@aol.com. Or you can contact my research advisor Dr. Susan Taylor in the Social Work Department at CSUS, (916) 278-7176 or email: taylorsa@csus.edu.

Directions to answer survey questions:

• PLEASE DO NOT WRITE IN ANY PERSONAL INFORMATION ABOUT YOURSELF other than questions on the demographic questionnaire (the last part of the survey).

• There are no right or wrong answers.
• The entire questionnaire should take approximately 30-45 minutes to complete.
• Please return the completed questionnaire in the self addressed stamped (Pre-paid) envelop provided.
• If you choose to participate in the research, your participation is strictly voluntary.
• You may withdraw at any time, for any reason, without penalty.
The Attitude toward Seeking Professional Psychological Help Scale was developed by Fischer and Turner in 1970. It has strong reliability and validity, and consists of 30 items. A list of 16 demographic questions is in part two of the questionnaire.

PART 1
The Attitudes Toward Seeking Professional Psychological Help (ATSPPH); Fischer & Turner, 1970). Instructions: Below are a number of statements pertaining to psychology and mental health issues. Please read each statement carefully and indicate your agreement or disagreement with each of the following statements. There are no right or wrong answers. You should answer each statement given below as honestly as possible in order for the data to be meaningful. Please do not leave any statements unmarked in order for the data to be meaningful.

1. Although there are clinics for people with emotional/personal problems, I would not have much faith in them (Choose one)
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

2. If a good friend asked my advice about an emotional/personal problem, I might recommend that he or she see a counselor. (Choose one).
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

3. I would feel uneasy going to see a counselor because of what some people would think (Choose one)
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

4. A person with a strong character can overcome mental conflicts by himself or herself, and would have little need of a counselor (Choose one)
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. (Choose one)
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family. (Choose one)
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychological help (choose one)
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

9. Personal and emotional troubles, like many things, tend to work out by themselves (choose one)
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

10. There are certain problems which should not be discussed outside of one’s immediate family (Choose one)
    ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

11. A person with a serious emotional disturbance would probably feel most secure in a good inpatient psychiatric unit (Choose one).
    ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

12. A person with a serious emotional disturbance would probably feel most secure in a good inpatient psychiatric unit (Choose one)
    ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

13. If I believed I was having a mental breakdown, my first inclination would be to get professional attention. (Choose one)
    ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

14. Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns. (Choose one).
    ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

15. Having been a counseling client is a blot on a person’s life (Choose one).
    ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

16. I would rather be advised by a close friend than by a psychologist, even for an emotional problem (choose one).
    ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

17. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help. (Choose one).
    ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree
18. I resent a person, professionally trained or not, who wants to know about my personal difficulties (choose one).
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

19. I would want to get psychological help if I were worried or upset for a long period of time (Choose one).
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

20. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts. (choose one)
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

21. Having been mentally ill carries with it a burden of shame (Choose one).
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

22. There are experiences in my life I would not discuss with anyone (Choose one).
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

23. It is probably best not to know everything about oneself (Choose one)
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

24. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

25. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help (Choose one)
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

26. I might want to have psychological counseling in the future (Choose one).
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

27. A person should work out his or her problems; getting psychological counseling would be a last resort (choose one).
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree

28. Had I received treatment in an inpatient psychiatric unit, I would not feel that it ought to be “covered up” (Choose one).
   ( ) 1 Agree   ( ) 2 Partly Agree   ( ) 3 Partly Disagree   ( ) 4 Disagree
29. If I thought I needed psychological help, I would get it no matter who knew about it (Choose one).
( ) 1 Agree  ( ) 2 Partly Agree  ( ) 3 Partly Disagree  ( ) 4 Disagree

30. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen (Choose one).
( ) 1 Agree  ( ) 2 Partly Agree  ( ) 3 Partly Disagree  ( ) 4 Disagree

PART 2

(DEMOGRAPHIC QUESTIONNAIRE; Damafing Keita Thomas, 2005) Instructions: Please answer the following questions about your personal background by placing an X on the line next to the category that best describes you or by writing in your answer.

1. What is your age?______________________

2. What is your sex?

_________ (1) Female
_________ (2) Male

3. What is your Marital status (please check one).

_________ (1) Single
_________ (2) Dating
_________ (3) Engaged
_________ (4) Married
_________ (5) Partnered
_________ (6) Divorced
_________ (7) Widowed

4. What country are you from? (Please check one):

_________ (1) Benin
_________ (2) Burkina Faso
_________ (3) Côte d’Ivoire
_________ (4) Ghana
_________ (5) Guinea
_________ (6) Guinea-Bissau
_________ (7) Gambia
_________ (8) Liberia
_________ (9) Mali
_________ (10) Mauritania
_________ (11) Niger
_________ (12) Nigeria
_________ (13) Senegal
_________ (14) Sierra Leone
_________ (15) Togo
_________ (16) Cape Verde

5. In what northern California City do you live? ____________________________

6. How confident are you in your English language ability (Please check one).

_________ (1) “Not at all”
_________ (2) “A little bit”
_________ (3) “Moderately”
_________ (4) “Quite a bit”
_________ (5) “Extremely well”

7. What is the highest education level you have obtained
8. At what age did you immigrate to the U.S?

9. Total number of family members living in household?

10. Total number of other relatives living in the same city as you?

11. Total number of months or years spent in the U.S since your first entry?

12. What was your age at the time of your first entry into the U.S?

13. Total household income before taxes or any other deductions last year.

14. How many days or weeks have you missed work due to your physical health?

15. What problems have you experienced with your physical or mental health? (please check all that apply):

16. Who do/did you contact for this/these problem(s)/concern(s)?
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<tbody>
<tr>
<td>4</td>
<td>counselor</td>
<td>10</td>
<td>medical doctor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>minister/clergy</td>
<td>11</td>
<td>nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>spiritual healer</td>
<td>12</td>
<td>other (please write in)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

Referral List for Mental Health, Counseling and Crisis Services

The minimal risks to your health and well-being that might be related to your participation in this research are limited to discomfort. However if you do feel uncomfortable, you can do any of the following: you can take a break and continue later, or you can end your participation in this research study. If you wish, you can pursue counseling or you can call a local mental health service provider or someone else of your choosing to discuss your feelings. Neither the researcher, her adviser, CSUS, and or any of their designee is responsible for any and all costs associated with seeking mental health services or any other services associated with this research for that matter.

Please see below a referral list of both local and national mental health services. Referrals are provided as a convenience and do not imply endorsement.

If in Immediate Danger call 911

The National Suicide Prevention Lifeline is a 24-hour, toll free suicide prevention service available to anyone in suicidal crisis. If you need help, please dial 1-800-273-TALK (8255). You will be routed to the closest possible crisis center in your area. Call for yourself, or someone you care about. Your call is free and confidential.

Additional Hotline Number
California State University, Sacramento - Center for Counseling and Diagnostic Services
For information call (916) 278-6252 or 916 278-6416

Vision Unlimited provide counseling for all ages  (916) 393-2203
New Pathways Counseling (916) 452-7481 or kchismark @diocess-sacramento.org
Asian Pacific Community counseling (916) 383-6783
Cross Creek Counseling (916)722-6100 or email www.croscreekcounseling.org
San Francisco (415) 520- 5567
Livermore psychotherapy & counseling (925) 243-9900
San Jose counseling center (408) 920-1730
Oakland, Merry Ross (510) 420-1979, email: merry@merryross.com
Depression and Bipolar Support Alliance- 1-800-826-3632
National Mental Health Association- 1-800-969-6642
National Alliance on Mental Illness-1-800-950- NAMI
National Institute of Mental Health Information Line: 1-800-647-2642
National Drug and Alcohol Treatment Hotline: (800) 662-HELP
National Domestic Violence Hotline: (800) 799-7233 OR (800) 787-3224
National Child Abuse Hotline: (800) 4-A-CHILD
National Youth Crisis Hotline: (800) HIT-HOME
National Runaway Switchboard: (800) 621-4000
Panic Disorder Information Line: (800) 64- PANIC
Project Inform HIV/AIDS Treatment Hotline: (800) 822-7422
REFERENCES


