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West African Immingrants' Attitude Toward Seeking Psychological Help

Damafing Keita Thomas

ACCEPTANCE

This dissertation, WEST AFRICAN IMMIGRANTS' ATTITUDES TOWARD SEEKING PSYCHOLOGICAL HELP, by DAMAFING KEITA THOMAS, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree Doctor of Philosophy in the College of Education, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chair, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty. The Dean of the College of Education concurs.

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ABSTRACT

WEST AFRICAN IMMIGRANTS' ATTITUDES TOWARD SEEKING PSYCHOLOGICAL HELP
by
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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. The following research questions and hypothesis were addressed: What are the specific mental and physical health concerns of West African immigrants in the U.S.? Where do West African immigrants with mental health problems seek help? The hypothesis was that higher acculturation into the U.S. society, severity of self-reported problems, and interactional attribution beliefs about mental health problems would be significant predictors of attitudes toward seeking psychological help. Approximately 600 questionnaires were mailed to first generation West African immigrants. A total of 126 surveys were received representing a return rate of 21%. Of this number 15 were not usable. Analyses were based on the remaining 111 surveys. Each survey packet included a demographic questionnaire, a referral list for national mental health, counseling and crisis services, a business reply envelope, and a battery of 4 instruments including the Attitude Toward Seeking Professional Psychological Help

Scale (ATSPPH), Behavioral Acculturation Scale (BAS), Brief Symptoms Inventory (BSI), and the Mental Health Locus of Origin Scale (MHLO). Descriptive statistics were computed (percentages & frequencies) to answer the first and second research questions. In addition, one multiple regression, using forced entry method was performed to predict West African immigrants' attitudes toward seeking psychological help as measured by the total scores on the ATSPPH, using the BAS, BSI, and MHLO scores as predictors. Finally, Pearson product moment correlation analyses were performed among the variables in examining the regression results. 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. 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.

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Damafing Keita Thomas

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ABBREVIATIONS

ATSPPH	Attitudes Toward Seeking Professional Psychological Help Scale
BSA	Behavioral Acculturation Scale
BSI	Brief Symptoms Inventory
MHLO	Mental Health Locus of Origin Scale

CHAPTER 1

MENTAL HEALTH ISSUES OF AFRICAN IMMIGRANTS IN THE UNITED STATES

At the beginning of the 21st century, more than 90% of the Black population in the United States were descendants from slaves brought forcibly to the U.S. (Rong & Brown, 2002). The Black immigrant population in the past four decades has increased from 125,000 in 1960 to more than 2.5 million in the year 2000, a 2000 percent increase over a period of 40 years (Camarota, 2001). An increasing number of Black persons in the U.S. are immigrants who come from African countries (Johnson, Farrell, & Guinn, 1997; Larsen, 2004). The Census 2000 showed that African immigrants in the U.S. numbered over 600 thousand, accounting for approximately 3% of the total foreign-born population (Dixon, 2006; Gibson & Lennon, 1999; Lollock, 2001). The increasing number and diversity of immigrants to the U.S. over the past few decades has given rise to questions about their mental health (Larsen, 2004) given the well-documented research asserting that resettling in a new country can lead to psychological distress for immigrants (Burnam, Hough, Karno, Telles, & Escobar 1987; Portes & Rumbaut, 1996). 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.

The few studies that have been published were conducted in Europe, Israel, and Canada (Faust, Spilsbury, & Loue, 1998). When compared with native-born individuals, a number of researchers have reported increased rates of mental illness among African immigrants. For instance, Bagley (1971) and Rwegellera (1977) found an increased prevalence of schizophrenia and affective psychosis among West Africans who immigrated to the United Kingdom (UK). Kidd (1965) reported an increase in general psychiatric morbidity among West African students, as compared to UK-born controls. Littlewood and Lipsedge (1981) noted an increased rate of schizophrenia in patients from West Africa. A study in the Netherlands found high rates of schizophrenia among young male immigrants from Morocco (Selten & Sijben, 1994). Increased rates of mental illness have been attributed to a number of factors. Nedetei (1986) attributed his finding of an increased prevalence of paranoid disorders among African patients in a London hospital to "cultural factors." He specifically noted that more than half of the 34 African patients in the sample attributed their illness to poison, evil spirits, witchcraft, or magic. Majid (1992) offered an alternative explanation for Africans' apparent vulnerability to certain forms of mental illness, arguing that it may result from the stress of migration, culture change, racial prejudice, and discrimination. Arieli and Ayche (1993) documented severe psychopathology among Ethiopian immigrants to Israel. They found a high prevalence of nightmares and sleep disturbances as long as 6 years after immigration. They also found that low income and high unemployment were associated with the presence of severe psychopathology. Ratzoni and colleagues (1993) found an increased prevalence of dissociative disorders among Ethiopian adolescent immigrants to Israel. Researchers in

Canada have also noted an increased risk of suicide among immigrants from South Africa (Rich, Kliewer, & Ward, 1988).

According to Faust and colleagues (1998), interpretation of the above body of research is problematic for a number of reasons. First, many of the databases and samples used for these studies were themselves problematic due to small sample size and selection bias. A number of studies examining rates of hospitalization for mental illness failed to distinguish between voluntary and compulsory admissions. Second, researchers may have misdiagnosed symptoms in patients from a different culture due to lack of familiarity with the norms specific to the patients' culture and misunderstandings due to differences in language. Third, classifications of patients' origins, for example, East Africa, West Africa, are inconsistent between studies, rendering inter-study comparisons difficult. Finally, it is unclear to what extent study findings pertaining to Africans who emigrate to countries outside of the U.S. are applicable to African immigrants within the U.S.

In summary, 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 addressed this specific population failed to consider a number of pertinent cultural forces which must be assessed when evaluating the mental health of immigrant populations. Thus, the purpose of this article 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.

Salient Cultural Factors

Family dynamics. According to Potocky-Tripodi (2002), mental health is intricately intertwined with family dynamics. According to Horowitz (1998), "family members can facilitate and provide care, report symptoms, and assist in decision-making" (p. 165). For immigrants, family involvement in mental health care may be more relevant or more important than it is for the general population (Potocky-Tripodi, 2002). Horowitz further describes several reasons for the impact of family dynamics on the mental health of immigrant populations. He 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. Thus, 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 (Horowitz, 1998). 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.

African immigrant families. The family is the cornerstone of African cultures and consists of an extended family that includes one's blood relatives from several generations (Kamya, 1997). According to Kamya, an 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 African immigrants to the U.S. (Potocky-Tripodi, 2002). Ross-Sheriff (1995) stated that although immigrants from

Africa "may share some similarities, they cannot be lumped together because of the many obvious distinctions [such as] culture, language, religion, and traditions" (p. 135). The African immigrant population is very diverse, composed of people from different countries of origin, ethnic groups, cultural and social backgrounds (Rong & Brown, 2002). This vast diversity, in addition to the limited research, makes it difficult to provide a complete picture of the entire African immigrant population in the U.S. Consequently, this article is focused on broader scope, on Somalian, Nigerian, and Ethiopian families. These three groups are being distinguished for two reasons. First, these immigrant populations represent the largest African immigrant populations within the U.S. (Dixon, 2006). In addition, existing research on African immigrant populations focuses on these cultural groups (e.g., Darman et al., 2001; Dodoo, 1997; Gali, 1998; Jenkins, 1988; Nwadiora, 1996).

In addition to the impact of family values, additional cultural forces impact the acculturation process of African immigrant populations. Darman and colleagues (2001) reported that after surviving the horrors of civil war and abysmal refugee camp conditions, Somalis face challenges as they attempt to readjust to their new lives in the U.S.

A variety of stress factors they may face include, post traumatic stress disorder (PTSD), social isolation, cultural conflicts in acceptable disciplinary methods of children, discrimination based on race and other aspects of their being, such as the wearing of traditional clothing and their Muslim religion. Darman and colleagues further explained that Somalis generally do not admit to serious psychological problems, and family members with mental illness are usually kept at home. This is partly due to their strong

religious belief that whatever happens to them is the will of Allah, which they believe should not be questioned. As a result, psychotherapy is non-existent in Somalia and personal difficulties are usually discussed only within family units (Darman et al., 2001).

When Nigerian 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 (Nwadiora, 1996). Many Nigerians have two or three jobs in order to survive economically in the U.S. while financially supporting their relatives in their native country (Nwadiora, 1996). The stress incurred by family responsibilities impacts their psychological well being and may contribute to domestic disputes, child neglect, and abuse (Nwadiora, 1996).

For Ethiopians, immigration stressors impacting the family result from its breakup, the unacceptability of hands on punishment of children and wives, adjustment/mental health concerns, living expenses, and health care cost (Jenkins, 1988). Loneliness and isolation from their cultural peers and from American neighbors also may contribute to African immigrants' high level of stress. In African cultures, neighbors interact frequently. It is also common for neighbors to stop by each others' homes without prior notification (Nwadiora, 1996). Another stressor may derive from the need to meet the demands imposed by family members in their native country. For example, African relatives in the native country often believe that their relatives in the U.S. have achieved high success and therefore are obligated to support the less fortunate who remain in their home country (Nwadiora, 1996).

African youth. Much of the research on migration has focused on adults;

however, understanding the impact of immigration on children, particularly adolescents, is very important. Foreign-born children and U.S. born children with immigrant parents account for nearly 20 % of American children and represent the fastest growing portion of the U.S. child population (Hamilton, 2005). According to Potocky-Tripodi (2002), immigrant and refugee children and adolescents experience the stressors of the migration process. Consequently, they are at risk for developing some of the same mental health problems as adults, such as depression, anxiety, and substance abuse; as well as problems unique to children and adolescents, such as disruptive acts characterized by antisocial behavior (e.g., conduct disorder and oppositional defiant disorder; Potocky-Tripodi, 2002). Rong and Brown (2002) reported that many U.S. students of Somalian origin were refugees of the civil war that erupted in their country in 1990. Some witnessed fighting and lost family members to the devastations of war; others were forced to flee their homeland and live in refugee camps. Many African immigrant youth from Sudan, Sierra Leon, Liberia, and Ethiopia have had experiences similar to those of the Somali students because their countries also were devastated by war (Rong & Brown, 2002).

In addition to intrapsychic and cultural conflicts among adult and child immigrant populations, intergenerational conflict (e.g., conflict between parents and children) is also very common in immigrant families (Ben-Porath, 1991; Carlin, 1990). According to Potocky-Tripodi (2002), intergenerational conflicts are influenced by the social context of immigration. More specifically, parental understanding of their culture of origin is conceptualized in terms of the cultural dynamics present at the time the family emigrated. However, as time passes, the cultural norms in the country of origin may change, but the immigrants' frame of reference may not. Thus, the parents may impose cultural

expectations upon their children that are outdated even in the country of origin. These experiences can cause children to hold resentment or disregard for parents, or may lead to children's rebellion (Potocky-Tripodi, 2002).

As African teenagers in the U.S. become acculturated, the gap between them and their parents widens. Consequently, the African adolescent may challenge parental decisions and question their authority (Nwadiora, 1996). Some of these intergenerational gaps may begin to manifest themselves in the children's aberrant behaviors, such as truancy, sexual promiscuity, failing in school, or physical or verbal exchanges between parents and teenagers (Nwadiora, 1996).

According to Zehr (2001), a recent New York City child abuse case underscored the challenges faced by both the immigrant parents as they attempt to raise their children in a new environment and American social service agencies as they attempt to deal with immigrant populations in a culturally sensitive manner that still protects children from maltreatment (Dugger, 1996; Faust et al., 1998). In this case, a Nigerian adult male defended himself against a charge of child abuse with the explanation that the corporal punishment he administered to his son, which broke the son's wrist, was standard child-disciplining behavior in Nigeria. Consultation with other Nigerian immigrants in the U.S., however, revealed that the father's behavior transgressed the bounds of acceptable behavior in Nigeria as well, and the father was charged with assault (Dugger, 1996).

Mental Health Issues Impacted by Family Dynamics

A review of the literature reveals that "migration is one of the most obvious instances of complete disorganization in the individual's role system" (BarYosef, 1980, p. 20). The stressors of the migration process typically lead to changes in family roles and

family dynamics, or the ways in which family members relate to one another (Potocky-Tripodi, 2002). These role changes may in turn place additional stress on family members. Jenkins (1988) revealed that in addition to problems of adjustment, the different roles of men and women in the U.S. create an equally pervasive stress for immigrant families. Furthermore, traditional forms of control over wives and children are not acceptable in the U.S. (Francis, 2000).

Most African immigrant groups come from male-dominant cultures in which men hold most of the power in family decision-making (Potocky-Tripodi, 2002). However, African immigrant families' coping resources and protective factors affect their responses to stress. If African immigrant families are highly adaptable, meaning they are able to change their power structure, role relationships, and relationship rules in response to stress, and if supportive community resources are adequate, then they will be able to re-establish balance in their family functioning (Ben-David, 1995). However, if African immigrant families lack these internal and external strengths, or if migration stressors overwhelm these strengths, than it seems that the mental health of African immigrant families would be worse than that of American native-born families (Ben-David, 1995).

Symptom Expression and Diagnosis

In addition to family dynamics, the assessment and treatment of mental health in African immigrants may be influenced by the symptom expression and diagnosis of their mental health concerns. Culture imprints mental health by influencing whether and how individuals experience discomfort associated with mental illness (Surgeon General, 2000). Idemidia (2004) explained that the cultural differences are often characterized through variations in the expression of symptoms of mental illnesses. For example,

Nigerians who are depressed complain of heaviness or heat in the head, crawling sensations in the head or legs, burning sensations in the body, and a feeling that their belly is bloated with water (Ebigbo & Iheaue, 1982). By contrast, individuals in the U.S. usually report feelings of worthlessness, inability to start or finish things, loss of interest in usual activities, and thoughts of suicide. Many symptom reports of depression among Africans do not result in suicides (Idemidia, 2004). This example illustrates that applying a standard definition of mental illnesses across different cultures may result in vastly different diagnoses.

When conveyed by tradition and sanctioned by cultural norms, characteristic modes of expressing suffering are sometimes called “idioms of distress” (Lu, Lim, & Mezzich, 1995). Idioms of distress often reflect values and themes found in the societies in which they originate. One of the most common idioms of distress is somatization, the expression of mental distress in terms of physical suffering (Lu et al., 1995). In general, diagnoses are culturally relative, or what is also referred to as *culture-bound*, meaning that they are recurrent patterns of behavior and experience that are specific to certain cultures (American Psychiatric Association [APA], 1994). A number of idioms of distress are well recognized as culture-bound syndromes and have been included in an appendix to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 1994). Researchers have found several culture-bound syndromes among Africans.

According to Ebigbo (1989), a combination of cultural conflicts can bring about anxiety-related types of psychopathology among Africans. These psychic symptoms originating from such cultural conflicts need to be understood from the African

perspective and idiom (Idemidia, 2004). According to many African cultural groups, pychophysiological 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 (e.g., 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.

Mental Health Treatment with African Immigrants

As aforementioned, Africa is a continent that comprises a diversity of cultures as evidenced by the numerous cultural practices found in its countries (Van Dyk & Nefale, 2005). In recent years, anthropologists have identified culturally distinct normative patterns of physical and psychological symptom definition, response, and help seeking behaviors across cultures (Lewis-Fernandez & Kleinman, 1995; Weidman, 1988). According to Van Dyk and Nefale (2005), research on the dynamics of culture is particularly relevant for Africans as many of Africa's countries have been affected by colonization. From the process of colonization, the cultures have become diluted; hence, one very rarely encounters a pure, traditional African culture (Van Dyk & Nefale, 2005). Practicing psychotherapy within such diverse settings has its challenges. One such

challenge involves dealing with clients who present with conflict in their life resulting from cultural clashes, mostly because they may not be acculturated in one pure culture (Van Dyk & Nefale, 2005)

Psychotherapy has been defined as a primarily verbal means of helping troubled individuals, families, or groups to change their thoughts, feelings, and behavior to reduce stress and achieve greater life satisfaction (Davison & Neale, 1996). Particularly important to the study of mental health treatment among African immigrants is the criticism that many clinicians mistakenly assume both that all individuals are free to engage in rational health related decision making and that they have the degree of knowledge about an illness and its treatment to act in a prescribed manner (Ell & Castañeda, 1998). This assumption fails to consider the interactive and dynamic interplay of culture and other relevant factors in health actions (Good, 1985).

Western practitioners who have attempted to use psychotherapy as a mental health treatment with Africans have reported considerable difficulty (Oyewunmi, 1986). Recommendations for therapeutic interventions applicable to the treatment of African immigrants' mental health issues have been researched and advocated for use with the target population. These interventions include cognitive behavioral therapies, family therapy, ubuntu therapy (i.e., incorporating African culture into psychotherapy), and the use of psychotherapy in conjunction with psychotropic medication. Each of these approaches is addressed below.

Cognitive behavioral therapies. Research has demonstrated the effectiveness of cognitive behavioral therapies for treating mental illness (particularly symptoms of depression and anxiety) among the general population (Dulmus & Wodarski, 1998;

Surgeon General, 2000).Both cognitive and behavioral approaches are time-limited, have a here-and-now focus, emphasize client education and active collaboration, use evaluation of apparent cause and effect relationships between thoughts, feelings, and behaviors, and use straightforward strategies to lessen symptoms (Potocky-Tripodi, 2002; Surgeon General, 2000). There have been very few reports of cognitive and behavioral therapies specifically with immigrants and refugees. However, "it is likely that similar effectiveness [to that of the general population] could be obtained with refugees and [African immigrants] if the linguistic and cultural issues are resolved" (Egli, Shiota, Ben-Porath, & Butcher, 1991, p. 167).

Cognitive and behavioral therapies are considered to be appropriate for African immigrants and refugees for several reasons: they use a targeted approach to symptoms; they are active and directive; they address concrete aspects of life; they are based upon mind-body holism, and they are more culturally neutral and responsive to individual needs, and less language-bound, than insight-oriented therapy (Egli et al., 1991). Further support for the likely effectiveness of these approaches with immigrants and refugees is the fact that they have had successful outcome in a variety of cultural contexts such as in Latin America, Asia, and Africa (Egli et al., 1991).

Cognitive and behavioral therapies are compatible with several religious belief systems, such as Buddhism and Hinduism (Egli et al., 1991)In using cognitive and behavioral approaches with African immigrants, clinicians should employ the following general guidelines: "behavioral analyses should be conducted within the cultural context, with the meaning of significant events, disabilities, and social disruptions considered accordingly; challenges to existing dysfunctional belief systems should be handled

delicately, frequently enlisting cooperative family members; dysfunctional global beliefs and assumptions should be dealt with after successfully applying behavioral treatments and establishing a trusting therapeutic relationship" (Egli et al., 1991, p. 171).

Family therapy. In working with African immigrant families, there are some *g*eneral principles that should be followed regardless of what specific therapeutic approach is used. Leigh (1998) 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 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 (Potocky-Tripodi, 2002). According to Nwadiora (1996), because therapy is foreign for most Africans, self-disclosure to the therapist becomes easier once a trusting relationship is established. He further explained that because of the relational culture of Africans, they are more likely to respond to a therapist who is more active and personal and who shows dignity (Nwadiora, 1996).

The general tone of the initial sessions should be geared toward the major accomplishments of the family as a unit with a de-emphasis on their crisis (Nwadiora, 1996). The therapist should first find out the history and intent of the family's immigration to the U.S. There should be opportunities 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 (Nwadiora, 1996). The approach used in the aforementioned New York City child abuse case demonstrated a useful method for American practitioners when dealing with

instances where child maltreatment is suspected; input from other immigrants of that ethnicity may be indispensable in interpreting the behavior and deciding on the correct course of action (Faust et al., 1998).

Therapists should be aware of the traditional African family hierarchy, which as noted earlier, is typically male-dominated and elder-dominated; female therapists and young therapists may need to take special steps to establish their credibility (Baptiste, Hardy, & Lewis, 1997; Gopaul-McNicol, 1993). They may enlist the aid of male or older co-therapists, or of elder family members who can serve as intermediaries between the therapist and the family (Gopaul-McNicol, 1993). If this is not possible, it is a good idea to openly address gender or age bias early in the therapeutic process before it has a negative effect (Baptiste et al., 1997). In accordance with many cultural protocols, practitioners should typically address family members in a formal manner, using titles and surnames rather than first names. Children should be addressed by their first names (Gopaul-McNicol, 1993). Another general principle is that practitioners should be flexible in scheduling appointments around the family's work and school schedules. Given that education and work are of critical importance to most African immigrant and refugee families, if attending therapy sessions consequences in the loss of wages, the family or individual may become resistant and indignant (Gopaul-McNicol, 1993).

Ubuntu approach. Van Dyk and Nefale (2005) proposed an alternative psychotherapy called ubuntu therapy that is aimed at incorporating African culture into psychotherapy. The ubuntu model of psychotherapy embraces Western theories and techniques to assess and treat mental illness and attempts to adapt them to African clients' unique situation and context, often calling for an integrated approach to

psychotherapy (Van Dyk & Nefale, 2005). Ubuntu therapy recognizes the simultaneous existence of one or more cultures within an individual, which may lead to tension and psychological problems. A closer examination of the dimensions, process, and techniques of ubuntu therapy, as outlined below, gives an indication of a client-centered approach and acknowledgment of distinctions that exists in pluralistic cultures found in African countries (Van Dyk & Nefale, 2005).

Madu (1997) wrote that African clients come to therapy to tell their "story." Thus, the first thing that the ubuntu therapist should do is to listen to the client telling his or her story. The therapist should then analyze the client's story and determine whether the problem lies on a psycho-theological, intra-psychic, or interpersonal level (Van Dyk & Nefale, 2005). Next, the therapist should decide, with the consent of the client, whether the problem should be addressed at an individual, family, group, or community level. Ideally, because of the interconnectedness and interdependent nature of the African culture, therapy with the whole family is strongly recommended (Van Dyk & Nefale, 2005).

During the different phases in the process of ubuntu therapy, the therapist can help the individual, family, group, or community to deal with its problems with the use of various techniques (Van Dyk & Nefale, 2005). Van Dyk and Nefale explained that these techniques include the following: *Burning platform*, a therapeutic technique to address clients' unfinished business. This technique (e.g., dancing around a fire, singing, clapping hands) allows for the process of burning the client's past. The burning platform can be done literally or symbolically, depending on whether the therapist feels comfortable using this technique (Van Dyk & Nefale, 2005). Another technique is the *life script*, including

parental messages that the client has incorporated and the decisions he/she has made in response to these conjunctions (Van Dyk & Nefale, 2005). The ubuntu therapist's role is to help the client map out his or her own life script. The therapist then assists the client in writing a new life script, in the context of his or her existing life situation. This ideally allows the client to heal on the dimension on which stress, anxiety, or conflict is experienced (Van Dyk & Nefale, 2005).

Psychotropic medication. Psychotropic medication has been found to be effective In treating a number of mental health problems such as depression and anxiety in the general population (Surgeon General, 2000). However, when considering psychotropic medication for African immigrants and refugees, there are some unique issues to be considered. One important issue is the fact that people from different ethnic backgrounds respond differently to drugs. For example, persons of Asian and African descent tend to metabolize certain drugs, such as antidepressants, more slowly than persons of European descent (Potocky-Tripodi, 2002). This means that persons of Asian and African descent tend to respond favorably to lower doses and have more adverse side effects with higher doses, compared to persons of European descent. There are many possible explanations for these differences, including genetics, environmental factors, diet, psychological, social, and cultural factors (Jaranson, 1991; Lin & Shen, 1991; Surgeon General, 2000). In using psychotropic medications, practitioners should be mindful that the medication treatment for individuals of non-European descent (e.g., African immigrants) should generally be initiated at lower doses than those recommended for individuals of European descent (Jaranson 1991).

Implications for Future Practice and Research

The purpose of this review was to provide 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 immigrants' 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. 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 PTSD. The recommended treatments for addressing these and other mental health concerns within the African immigrant population, includes cognitive behavioral therapies, family therapy, ubuntu 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 because of African immigrants' personal and social protective factors

including cultural influences, family structures, and social networks (Potocky-Tripodi, 2002). Nonetheless, the high risk remains and intervention efforts are warranted.

Practical Implications

Findings of this literature review hold important practical implications for Psychologists and other clinicians. In recent years, immigrants from Africa have arrived in significant numbers, expanding the multicultural nature of the U.S. This implies that mental health service practitioners will be in increasing contact with the target population. It seems that African immigrants will continue to play an increasingly important role in communities across the U.S., thus addressing their mental health needs seems important (Downs-Karkos, 2004). According to the Surgeon General (2000), 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 (Center for Mental Health Services [CMHS], 1998; Snowden, 1999; Takeuchi & Uehara, 1996).

Research and clinical practice have propelled advocates and mental health Professionals to press for linguistically and culturally competent services to improve utilization and effectiveness of treatment for different cultures (CMHS, 1998; Surgeon General, 2000). Psychologists and other clinicians have important roles in ensuring that this happens. Culturally competent services incorporate respect for and understanding of, ethnic and racial groups, as well as their histories, traditions, beliefs, and value systems (CMHS, 1998). Practitioners should not become overwhelmed with the range of

knowledge they must develop if they are to serve African immigrants effectively. Practitioners may need to consult with service providers who are expert in serving African immigrants to upgrade their knowledge and skills. There is some beginning research on African immigrants to the U.S. Practitioners should review such research to develop insight into the immigration process and the particular mental health issues relevant for African immigrants. Learning about these issues will provide practitioners with a unique frame of reference.

The above review of mental health issues of African immigrants provides crucial information needed to help practitioners design culturally competent mental health services for the target population. For example, an important point derived from the review on symptom expression and diagnosis is that practitioners should be mindful of the concepts of universality and cultural relativity when assessing African immigrants' mental health in order to avoid misdiagnosis. In their discussion of families of African origin, Black and Debelle (1995), noted that therapists working with people of African descent in the U.S. should be aware of both cultural similarities and differences, raising questions and drawing distinctions so that the important differences can be discussed, understood, and celebrated.

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 be a basis for advocacy for African immigrants.

Kamya (1997) 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. Ahearn (2000) has articulated a clear agenda for future research on the psychosocial wellness of refugees, which appears to be applicable to research with African immigrants. First, Ahearn 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.

Second, Ahearn argues that the preponderance of existing research examines the individual, his or her reaction, and interventions useful at this level. As a person's support system is a crucial factor in psychosocial adjustment, the family and community should also become the foci for investigation. The social and cultural system of refugees and African immigrants, the supports of extended family, employment, and religion/spirituality are areas for understanding the protective factors of a refugee's or an African immigrant's wellness. Finally, Ahearn explains that there are very few examples of studies of the long-term adjustment of refugees and African immigrants as most existing studies are short-term comparisons that have little relevance or applicability to other situations. Longitudinal investigations and/or long-term case studies would contribute to clinicians' understanding of African immigrants' adaptation.

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 (Faust et al., 1998). 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. Because 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 (Colorado Trust, 2002).

It is apparent that significant gaps exists 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

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CHAPTER 2

WEST AFRICAN IMMIGRANTS' ATTITUDES TOWARD SEEKING PSYCHOLOGICAL HELP

There is increasing movement in the psychology profession to understand cultural and ethnic factors in order to provide appropriate psychological services for diverse clients (Surgeon General, 2000). Studies show that health care and social service outcomes are more effective when they are provided in a culturally competent manner (e.g., Atkinson, 1985; Sue, Zane, & Young, 1994). Cultural competence is a set of behavioral or thinking patterns shared by a group of people to work effectively in cross-cultural situations such as services provided to immigrants (Cross, Dennis, Bazion, & Isaacs, 1989). The tremendous 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 new 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 for 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). Previous research has examined the adjustment of refugees or immigrants in terms of education, language, economy, society, and their psychological well-being (Haines, 1989; Kamya, 1997). However, Black immigrants in the U.S. have been considerably less researched compared to Hispanic, Jewish, Russian, and Asian immigrants (Dodoo, 1997; Kamya, 1997). The few studies that have been done with Black immigrants in the U.S. (e.g., Butcher, 1994; Dodoo 1991; Kalmijn, 1996; Model, 1991, 1995) have involved a comparison of American and immigrant Blacks, and has either defined the latter as one homogenous immigrant entity (Chiswick 1979; Dodoo, 1991) or focused mainly on Caribbean immigrants (Butcher, 1994; Kalmijn, 1996; Model, 1991, 1995). Limited attention has been given to the African born population in the psychology literature, despite the fact that an increasing number of Black persons in the U.S. are immigrants who come from African countries (Johnson, Farrell, & Guinn, 1997; Larsen, 2004).

African immigrants are not a homogenous population; rather, they are composed Of people from different countries of origin, ethnic groups, and cultural and social backgrounds (Rong & Brown, 2002). This vast diversity, in addition to the limited research, makes it difficult to provide a complete picture of the entire African immigrant population in the U.S. Consequently, this study takes focuses on West African immigrants in the U.S. West African immigrants are being distinguished for two reasons. First, this population represents the largest proportion of African immigrant populations within the U.S. (Dixon, 2006). In addition, West African immigrants have been less researched compared to other African immigrant populations (e.g., Bagley, 1971; Kidd,

1965; Littlewood & Lipsedge, 1981; Nwadiora, 1996; Rwegellera, 1977). West Africans are Blacks from the westernmost region of the African continent. Geopolitically, the United Nations' (UN) definition of Western Africa includes the following 15 countries: Benin, Burkina Faso, Ivory Coast, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sénégal, Sierra Leone, and Togo. In addition, the country Cape Verde is sometimes included due to its membership in the Economic Community of West African States (United Nations, 2007; Wikipedia, 2007).

Several important rationales exist for clinical research with West Africans. First, Ross Sheriff (1995) stated that although immigrants from Africa "may share some similarities, they cannot be lumped together because of the many obvious distinctions [such as] culture, language, religion, and traditions" (p. 135). Second, this study is concerned with West Africans on the basis that, while it is necessary to examine the heterogeneity of African immigrants, of equal importance is the consideration of cultural diversity within and between Africans. Research is needed to better understand the impact of these differences on West African immigrants' mental health and their ability and willingness to seek traditional Western care. Because there is a lack of adequate research with the target population in this area, significant issues that require attention include issues relating to attitudes that West African immigrants have towards seeking professional psychological help for their mental health problems. Finally, 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.

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, Menton, Okawa, & Teklamarian, 2001). Darman et al. listed a variety of stress factors that African immigrants may face including social isolation, discrimination, and cultural conflicts. Of particular concern are the psychological effects of migration. As with all Black African immigrants, race is an undeniable component of their experience. Kamya (1997) describes this as the 'double invisibility' West African immigrants experience because of their race and their origin. Kamya also explains that African immigrants face further challenges as they attempt to adjust to their new lives in the United States. He listed a variety of psychological stress factors including social isolation, worry about/missing family members, cultural conflicts in acceptable discipline of children, and discrimination based on race and other aspects such as traditional clothing and religion. 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 (Nevid, Rathus, & Greene, 1997).

Generally, West African immigrants do not admit to serious psychological problems, and persons with mental illness are usually kept at home (Darman et al., 2001). Psychotherapy is typically non-existent in many African countries, and personal difficulties are usually discussed only within family unites (Darman et al., 2001). It has been suggested that, when attempts to solve problems on their own or in the intimate

circle of friends and family members fail, ethnic minorities often seek help from community figures such as preachers or spiritual healers (Zhang, Snowden, & Sue, 1998). Zhang et al. further explained that only after the escalation of symptomatology will medical and mental health professionals be considered. Many ethnic groups in the U.S. are characterized by this paradox of high risk and underutilization of mental health services (e.g., Hispanic and Asian Americans; Gim, Atkinson, Whiteley, 1990; Miville & Constantine, 2006). To meet the mental health needs of ethnic minority populations, insights in help-seeking attitudes and behaviors are greatly needed. The mental health profession has a long history of researching the components of help-seeking attitudes and behaviors. One reason for continued interest in this topic is that psychologists recognize that the attitudes and opinions of the population they serve affect both the utilization and success of that service (Grencavage & Norcross, 1990; Stiles, Shapiro, & Elliot, 1986).

Attitudes Toward Seeking Psychological Help

To understand the utilization of psychological services, researchers have examined various factors that may be related to help-seeking behavior. One such factor is people’s attitudes toward seeking psychological services (Leong, 1999). For example, several researchers have suggested that a better understanding of people's help-seeking behavior could be gathered by using Ajzen and Fishbein's (1980) theory of reasoned action (TRA; Bayer & Peay, 1997; Codd & Cohen, 2003; Halgin, Weaver, Edell, & Spencer, 1987). Specifically, TRA asserts that people's actions are decided through a series of rational judgments. The most direct predecessor of a behavior or action is the intention to perform the behavior. Underlying an individual's behavioral intent are the person's attitudes about the behavior (i.e., the positive and negative feelings about the

behavior). From this perspective, then, attitudes are distinct from intentions yet one of the most important determinants of intentions. Indeed, consistent with this perspective, studies have shown that the best predictor of help-seeking intent is the person's attitude toward seeking professional help (e.g., Bayer & Peay, 1997; Halgin et al., 1987).

There are no published reports on attitudes toward seeking psychological help for West African immigrants in the U.S. A major problem with the limited studies done on African immigrants is that they are restricted to student populations (e.g., Essandhoh, 1992). Essandhoh found that African students in the U.S. (61 % of which are from West Africa) preferred informal sources of counseling (e.g., foreign student advisors) over established counseling and mental health centers. The belief in divine destiny and in chance factors influences the attitudes African students hold toward seeking psychological help (Essandhoh, 1992). The idea of Western psychotherapy is foreign to most Africans (Nwadiora, 1996). Undoubtedly, West Africans prefer to use treatments that recognize their ways of thinking and their value system (Gordon, 1990; Idemudia, 1995; 2003; Madu & Idemudia, 1997). Idemudia (2003) suggested that, given this perspective, Africans who have received Western education are more likely to seek psychological help.

If this holds true for Africans in general, it seems plausible that this also holds true for West African immigrants in the U.S. As research suggests, many of the African immigrants immigrate to the U.S. to pursue graduate level education (Butcher, 1994). As such, it seems reasonable to expect that many West African immigrants living in the U.S. are likely to seek psychological help and will probably possess positive attitudes toward seeking psychological help. After a comprehensive review of literature concerning

attitudes toward seeking psychological help for problems, three sets of variables emerged as salient and warranting further study: (a) acculturation, (b) severity of distress/problems, and (c) beliefs about the causes of mental distress (i.e., attribution).

Acculturation

Acculturation is "…the process of maintaining an identity with one's culture or origin while adapting to the host culture" (Kakaiya, 2000, p. 139). Acculturation highlights the great heterogeneity within racial and ethnic immigrant groups, and it is also related to several mental and physical health variables (Ponterotto, Baluch, & Carielli, 1998). Acculturation processes are believed to shape critical aspects of psychological function, including core beliefs, attitudes, and expectations of behaviors (Ponterotto et al., 1998). It has been suggested that the attitudes and behaviors of immigrants and other ethnic minorities regarding wellness and health, including mental health, are likely to be influenced by acculturative processes (Kim, Yang, Atkinson, Wolfe, & Hong, 2001).

Essandoh's (1992) study indicated that African college students with a high level of acculturation reported more positive attitude toward psychological help seeking than those who were low or medium on the acculturation scale. The findings of this study also indicate that acculturation levels significantly differentiated between participants both in self-reported symptoms and in their attitude toward seeking psychological help. Idemudia (2003) suggests that Africans who have acquired both African and Western values (i.e., bicultural) are more likely to seek the help of a psychotherapist. Thus, it seems plausible to infer that the higher the acculturation level of West African immigrants in the U.S., the more likely they are to identify a positive attitude toward seeking psychological help.

The importance of acculturation has been illustrated in a number of studies with other ethnic minorities. Tata and Leong (1994) studied Chinese Americans and found that those with traditional Chinese values, specifically those who are less individualistic and more family-oriented, have less positive attitudes toward seeking psychological help. Some researchers have found that Jewish Americans have more positive attitudes toward seeking psychological help than do other cultural groups (Fischer & Cohen, 1972; Greenley & Mechanic, 1976; Kadushin, 1969). Greenley and Mechanic (1976) found that students who use psychiatric services are less oriented to the traditional student culture and more oriented to the counterculture. It seems plausible to infer similar assumptions made from the aforementioned studies with other ethnic minorities also be made of West African immigrants in the U.S because of the paucity of studies in this area with West African immigrants. These findings suggest that West African immigrants' level of acculturation, in addition to norms of their cultural group with regard to seeking psychotherapy, may affect their propensity to seek psychological help.

Severity of Distress/Problems

Research consistently shows that individuals are more likely to seek counseling when personal problems exceed their capacity to cope, and when distress reaches motivating levels (Cepeda-Benito & Short, 1998; Ingham & Miller, 1986; Kelly & Achter, 1995; Rickwood & Braithwaite, 1994). According to Goodman, Sewell, and Jampol (1984) and Mechanic (1975), individuals are more likely to seek counseling when they perceive their problems as more severe than the problems of others and when they sense that their decision to do so will reduce their feeling of distress. According to Essandoh (1992), mental health symptoms as measured by the Brief Symptoms Inventory

(BSI), is not a strong correlate of attitudes toward seeking psychological help for African students. However, there could be several reasons for this finding. Essandoh explained that the results may be due to the perception given by African college students to their problems. More specifically, he explained that the majority of the African students in his study perceived themselves as having immigration and educational concerns as evidenced by their reported preference to seek help from foreign student advisors or other faculty members.

Similarly, Idemudia (2003) indicated that the characteristics of different cultures also reflect on symptom report, and that symptoms or descriptions of them can be very dissimilar in different societies (Idemudia, 2003). For example, Nigerians who are depressed complain of heaviness in the head, crawling sensations in the head or legs, burning sensations in the body, and a feeling that their belly is bloated with water (Edigbo & Ihezue, 1982). By contrast, people in the United States report feeling worthless, being unable to start or finish anything, losing interest in usual activities, and thinking of suicide. Natives of China, on the other hand, do not report loss of pleasure, the helplessness or hopelessness, guilt, or suicidal thoughts seen in depressed North Americans (Kleinman, 1980).

The tendency to express somatic rather than emotional complaints for mental health distress has been reported for other ethnic minority groups in the U.S., including Chinese Americans (Ying & Miller, 1992), Asian Americans (Uba, 1994), and Pakistani Americans (Raja (2004). 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.

Problem Attribution

Anthropologists and psychologists have long recognized that beliefs about causes and cures of mental illness vary from culture to culture (Barker, 1994; Congress & Lyons, 1992; Freedman, 1988; Jack, Harrison, & Airhihennbuwa, 1994; Kleinman, 1987; Putsch, 1988; Schwartz, 1985; Torrey, 1972). The way in which people come to understand their mental distress has been shown to be strongly related to wider cultural health beliefs (Helman, 1985, 1990; Herzlich & Pierre, 1987). Most societies attribute their distress to both natural and supernatural causes (Furnham, Akande, & Baguma, 1999; Landy, 1977). According to Helman (1990), beliefs of individuals of migrant communities are influenced by the values of both their home culture and the host society.

As aforementioned, Africa is a continent that is culturally diverse. Although there are cross-cultural and ethnic differences in Africa, there is a general belief that both physical and mental diseases originate from various external causes such as breach of a taboo or customs, disturbances in social relations, hostile ancestral spirits, spirit possession, demoniacal possession, sorcery, natural causes, and affliction by God or gods (Idemudia, 2003). The common element in the African belief system is simply that physical and mental illness is the result of distortions or disturbance in the harmony between an individual and the cosmos, which may mean family, society, peers, ancestors,

or a deity (Idemudia, 2003). Cultural attitudes toward illness particularly affect the perception regarding the availability of professional help (Furnham, 1997). The issue of acceptability of professional help is particularly important because the theories of cause and cure of diseases must be meaningful to individuals in terms of the realities of their understanding in order for treatment to be effective (Furnham, 1997).

This study investigated the role of the three aforementioned factors on West African immigrants' attitudes toward seeking professional help. The following research questions and hypothesis were addressed:

1. What are the specific mental and physical health concerns of West African immigrants in the U.S.?

2. Where do West African immigrants with mental health problems seek help?

3. The hypothesis was that higher acculturation into the U.S. society, severity of self-reported problems, and attribution beliefs about mental health problems would be significant predictors of attitudes toward seeking psychological help.

Method

Participants

The sample consisted of 111 first generation sub-Saharan West African immigrant adults living in the U.S. Residence of respondents included 3% Alabama, 2% Connecticut, 2% Florida, 42% Georgia, 1% Illinois, 3% Kentucky, 4% Maryland, 1% Massachusetts, 2% New Jersey, 22% New York, 1% North Carolina, 6% Ohio, 2% Oklahoma, 4% Pennsylvania, 5% Tennessee, and 2% of respondents who did not indicate their state of residence. Their countries of origin were as follows: 1% Benin, 2% Burkina

Faso, 1% Ivory Coast, 33% Ghana, 1% Gambia, 2% Liberia, 21% Mali, 4 % Mauritania, 4% Niger, 22% Nigeria, 3% Senegal, 6% Sierra Leone, and 2% Togo.

Seventy percent of respondents were men and 30% were women. The age of the respondents ranged from 20 to 72 years, with an average of 42.52 years (*SD* = 12.44). Levels of education completed by respondents included 1% elementary school, 2% some high school, 8% high school diploma, 9% 2-year college, 14% some 4-year college, 20% 4-year college, 10% some graduate/professional school, and 37% graduate/professional school. In terms of self-reported ability to speak English, 5% reported "a little bit," 14% "moderately," 15% "quite a bit," 65% "extremely well," and 1% did not indicate their English proficiency.

Sixty percent of the respondents were married, 19% single, 5% dating, 2% engaged, and 5% divorced. The number of family members living in household of the respondents ranged from 0 to 8, with an average of 2 (*SD* = 1.85), and a median of 4. The number of other relatives living in the same city as the respondents ranged from 0 to 20, with an average of 2 (*SD* = 4.46), and a median of 2. The length of stay in the U.S. ranged from 2 months to 38 years, with an average of 14 years (*SD* = 121.12). The age of first entry into the U.S. ranged from 6 to 69 years, with an average of 27.87 years (*SD* = 9.4). Respondents' total household income before taxes or any other deductions included 11% under $10,000, 9% $10,000 - $19,999, 7% $20,000 - $29,999, 6% $30,000 - $39,999, 15% $40,000 - $49,999, 9% $50,000 - $59,999, 9% $60,000 - $69,999, 34% $70,000 or more, and 4% of respondents who did not indicate their total household income.

Measures

Demographic variables assessed included age, marital status (i.e., single, partnered, married, divorced, widowed), country of origin (i.e., checklist of 16 West African countries), current state of residence (write in format), English language ability ("Not at all," "A little bit," "Moderately," "Quite a bit," "Extremely well"), years of education (elementary, middle, high school, college, graduate school), age of immigration to the United States, number of family members living in household, number of relatives living in the same city, total time spent in the U.S. since first entry, months or years elapsed since last entry and age at first entry, and annual income.

The specific concerns of West African immigrants and how they seek help were assessed using two questions on the demographic sheet. The first question was: "What problems have you experienced with your physical or mental health?" Respondents were asked to indicate their specific concerns by checking all that apply using a checklist. Response options were based on previous research with African immigrants (Darman et al., 2001; Dodoo, 1997; Kamya, 1997). Response options included: (1) lack of English skills, (2) limited employment opportunities, (3) need for affordable housing, (4) lack of health care coverage, (5) social isolation, (6) worry about/missing family members, (7) academic problems, (8) non recognition of African credentials in the U.S., (9) immigration issues, (10) cultural conflicts in acceptable disciplining of children, (11) pressure/cultural conflicts in acceptable choice of mate, (12) discrimination based on race and other aspects such as traditional clothing and religion, (13) war trauma, (14) voyage trauma, (15) gender and intergenerational conflict within families, (16) gap between

experiences and education in their former country and current employment in the U.S., and (17) other (write in format).

For each concern checked, respondents were asked to indicate "Who do/did you contact for this problem/concern?" Response options included: (1) psychiatrist, (2) psychologist, (3) social worker, (4) counselor, (5) minister/imam/clergy, (6) spiritual healer, (7) traditional healer/medium, (8) friends, (9) family member, (10) medical doctor, (11) nurse, and (12) other (write in format).

Attitude toward seeking psychological help. Attitude toward seeking psychological help was assessed using the Attitude Toward Seeking Professional Psychological Help scale (ATSPPH; Fischer & Turner, 1970). It consists of 29 items and 4 subscales: (a) Perception of Need for Help (e.g., At some near future, I might want to have psychological counseling); (b) Tolerance to Stigma (e.g., I would feel uneasy going to a counselor because of what some people would think); (c) Openness in Interpersonal Relationship (e.g., There are some experiences in my life I would not discuss with anyone), and (d) Trust in Experts (e.g., If a good friend asked my advice about a mental problem, I might recommend that he see a counselor). Items are rated on a 4-point Likert scale (strongly disagree to strongly agree). A total score is generated with the range of scores ranging from 29 to 116. Higher scores indicate a more positive attitude toward seeking psychological help.

Only the total score of the ATSPPH was used for this study. Although the components that make up help seeking attitudes can be scored, Fischer and Turner (1970) recommended using only the total ATSPPH score because it is the most reliable. Fischer and Turner (1970) reported that test-retest reliabilities on a student sample ranged from

.86 for a 2-week interval to .84 for a 2-month interval. Additionally, the ATSPPH was reported to have good construct validity in that significant point biserial correlations were found between individuals' scores on this measure and their psychological help-seeking behavior (Fisher & Farina, 1995). When this instrument was used with predominantly Westerners, the internal consistency was .83, and it was evaluated as a relatively reliable instrument (Fisher & Turner, 1970). The Cronbach α reliability was .80 for a Korean sample, (Yoo, Goh, & Yoon, 2005), and .83 for the current sample.

Behavioral Acculturation Scale (BAS). The BAS was developed by Szapocznik et al. (1978) to assess Cuban immigrants' acculturation to the United States along a behavioral dimension. It was developed to measure self-reported behaviors and value dimensions. It measures the extent to which the immigrant has adopted American customs, habits, language, and life style. The BAS has eight language items, three customs items, four items on recreation-related habits and lifestyle, and nine items on behavior preferences. The scale consists of 24 items that ask the respondent to report on a 5-point Likert scale the relative frequency with which he or she engages in American versus Cuban behaviors.

The BAS is not ethnically specific. It outlines a psychosocial model of acculturation to account for the occurrence of intergenerational/acculturational differences in immigrant families. There are five possible responses to each BAS item, ranging from (1) "Hispanic all of the time" or "completely Hispanic" to (5) "American all of the time" or "completely American." For the present study, items for Hispanic culture were revised by using "West African" instead of "Hispanic." An example is "How much do you enjoy West African music?" For question 13 of the BAS, "My way of relating to

my fiancée is…" was replaced by "My way of relating to my spouse/significant other is…" Response options range from (1) not at all to (5) very much. Scores range from 24 to 120, with higher scores indicating maximum acculturation. Only the total score of degree of acculturation was used in this study.

A BAS validation study with a sample of Cuban Americans found high internal consistency, high test–retest reliability, and good construct validity (Szapozcznik et al., 1978). Internal reliability of the BAS was determined with a sample of 69 Cuban high school students and 50 White American high school students (r = .97). The correlation between parallel (Spanish and English) forms of the scale was high (r = .88, p < .001) when administered to 27 bilingual respondents. The test-retest reliability was obtained by administering the scale four weeks apart to 30 subjects (r = .96, p < .001). Evidence for the scale's validity is provided by Szapocznik et al.'s findings that, consistent with their hypotheses, the BAS was significantly related to the individual immigrant's age, gender, and years of residence in the U.S. They reported that the scale is applicable for use with other immigrant groups, and that up to five items can be deleted from the BAS without substantially affecting its psychometric properties. The reliabilities were .80 for the Russian, .83 for the Jewish, and .84 for the American subscales (Birman, & Tyler, 1994). The Cronbach α reliability was .87 for the current sample.

Brief Symptoms Inventory (BSI). Self-reported symptoms of psychological distress were assessed using the BSI (Derogatis, 1975). The BSI is a 53-item, brief psychological self-report symptom scale for assessing psychological symptoms. It was developed as a short alternative to the Symptom Checklist (SCL-90-R; Derogatis & Melisaratos, 1983). There are nine primary symptom dimensions and three global indices

of distress (Derogatis & Melisaratos, 1983). The primary symptom dimensions include: (a) Somatization (SOM); (b) Obsessive-Compulsive (O-C); (c) Interpersonal Sensitivity (I-S); (d) Depression (DEP); (e) Anxiety (ANX); (f) Hostility (HOS); (g) Phobic Anxiety (PHOB); (h) Paranoid Ideation (PAR); and (i) Psychoticism (PSY). The global indices of distress include: (a) General Severity Index (GSI); (b) Positive Symptom Distress Index (PSDI); and Positive Symptom Total (PST). Interpretation consists of three levels: first, global scores which indicate overall distress; second, primary symptom dimension which can highlight specific areas of psychopathology; and third, specific focus on discrete symptoms by looking at individuals items (Derogatis & Melisaratos, 1983). Only the total score of the BSI was used for this study. The total sum shows the frequency of psychiatric symptoms. The range of achievable scores is 0 to 212, with higher scores indicating the frequency of psychiatric symptoms.

Internal consistency coefficients of primary symptom dimensions range from .71 (on PSY) to .85 (on DEP). Test-retest reliability coefficients of primary symptom dimension range from .68 (on SOM) to .91 (on PHOB), and .80 (on PST) to .90 (on GSI) for the global indices (Derogatis & Melisaratos, 1983). The correlation between the BSI and the SCL-90- ranges from .92 (on PSY) to .99 (on HOS) for the primary symptom dimensions (Derogatis & Melisaratos, 1983). The convergent validity between the BSI and the MMPI is strong. The construct validity of the BSI is moderately strong providing further support that the BSI measures what it intends to measure (Derogatis & Melisaratos, 1983). The Cronbach α reliability was .95 for the current sample.

Mental Health Locus of Origin Scale (MHLO). Attribution of problems (locus of responsibility) were assessed using the MHLO (Hill & Bale, 1980). It is a bipolar

construct pertaining to beliefs about the etiology of maladaptive behavior. At one end of the dimension ("endogenous") lie beliefs emphasizing genetic and physiological factors. The opposite pole ("interactional") consists of beliefs that focus on the interactions between an individual and the social environment. The MHLO scale assesses beliefs about the etiology of psychological problems, which includes 13 endogenous and seven interactional items. Examples of items include: "The cause of most psychological problems is to be found in the brain," "The cause of many psychological problems is bad nerves." The 20-item MHLO scale is administered in a six-point Likert format, and has a potential range of 20 (interactional extreme) to 120 (endogenous extreme), with a mid-point of 70. Reported alpha for scores of this scale was .76. Validity was supported by correlating the MHLO with Mental Health Locus of Control (MHLC) and Multidimensional health locus of control (MHLC) measures (Hill & Bale, 1980). The Cronbach α reliability was .79 for the current sample.

Procedure

Approximately 600 questionnaires were mailed to potential participants; however out of the surveys mailed it could not be determined how many individuals actually received them. A total of 126 surveys were received representing a return rate of 21%. Of this number 15 were not usable for several reasons, for example some did not provide demographic data, too many items were left unanswered, and others did not meet the criteria of the study (e.g., age of immigration or country of origin). Analyses were based on the remaining 111 surveys.

Participants were recruited from Northeast, Midwest, South, and West regions of the U.S. because of the availability of volunteers who have contacts with professional and

social groups in these regions. In each of the regions, one individual acted as representative for the study and responsible for distributing survey packets. Participants were recruited through social functions and settings such as Independence Day celebrations, certain restaurants, churches, and African hair braiding salons, and apartment complexes where high concentrations of West African immigrants live (Cornelius, 1982). Additionally, the snowball method of using existing social networks of willing participants was employed.

Participants were instructed to complete the anonymous survey only if they were first generation immigrants from one of the 16 countries in West Africa, and immigrated to the U.S. at the age of 18 years or older. They were also instructed to return the completed questionnaire in a provided stamped envelope directly to the primary investigator. Anonymity was provided by asking participants not to write their names. Participants were given a choice between English and French language versions of the measures. Due to their colonial pasts, the majority of the countries in West Africa have adopted French or English as national languages (African Cultural Center, 2007). According to Shin and Rosalind (2003), of the African born age 5 and older who spoke a language other than English at home, 65.8% reported speaking English "very well." The majority of respondents (98%) requested the English version of the survey packet.

All items in each of the instruments and demographic questionnaire were translated and back-translated by three independent translators fluent in both French and English. Each survey packet included a demographic questionnaire, a referral list for national mental health, counseling and crisis services, a business reply envelope, and a battery of 4 instruments including the ATSPPH, BAS, BSI, and MHLO.

Analysis

Descriptive statistics were computed (percentages and frequencies) to answer the first ("What are the specific mental and physical health concerns of West African immigrants in the U.S?") and second ("Where do West African immigrants with mental health problems seek help?") research questions. In addition, one multiple regression, using forced entry method was performed to predict West African immigrants' attitudes toward seeking psychological help as measured by the total scores on ATSPPH, using the BAS, BSI, and MHLO scores as predictors. It was hypothesized that higher acculturation into the U.S. society, severity of self-reported problems, and interactional attribution beliefs about mental health problems would be significant predictors of attitudes toward seeking psychological help. Finally, Pearson product moment correlation analyses were performed among the variables in examining the regression results.

Results

Descriptive Analyses

The frequency of days respondents reported that they missed work due to their physical health ranged from 0-42, a median of 0, an average of 3 (SD = 6), and the majority (63%) reporting zero days. Seven participants did not respond to this question, resulting in an adjusted N = 104. The mental and physical problems that were endorsed by most respondents were the following: headaches (53%), worry about/missing family members (37%), stomach problems (34%), stress (34%), anxiety (23%), cultural conflicts in acceptable disciplining of children (25%), depression (13%), pressure/cultural conflicts in acceptable choices of mate (12%), nightmares (11%), gender and intergeneration

conflict within families (9%), other physical problems (8%), social isolation (7%), war trauma (4%), voyage trauma (2%), and other mental health problems (1%) (see Table 1).

Table1.
Summary of Mental & Physical Health Concerns of West African Immigrants (*N*=111)

Concerns	*% No*	*% Yes*
Mental Health Concerns		
Voyage trauma	98	2
War trauma	96	4
Social isolation	94	6
Gender & intergenerational conflict within families	91	10
Nightmares	89	11
Pressure/cultural conflicts in acceptable choice of mate	88	12
Depression	87	13
Anxiety	77	24
Cultural conflicts in acceptable disciplining of children	75	25
Stress	65	34
Worry about/missing family members	63	37
Other mental health problems	—	1
Physical Health Concerns		
Stomach problems	66	34
Headaches	46	53
Other physical problems	–	1

Respondents generally sought help for most of their problems from medical doctors (46%), followed by the use of friends and family members (tied at 30% each), minister/imam/clergy (18%), traditional healer/medium (9%), no one (7%), nurse (5%), and spiritual healer (5%). Respondents were the least likely to seek help from mental health professionals, such as counselor (5%), psychologist (3%), social worker, (3%), and psychiatrist (2%), and 1% of respondents reported use of prayer for their problems (see Table 2).

Table 2

Summary of Help-Seeking Resources of West African Immigrants (*N*=111)

Source	*% No*	*% Yes*
Psychiatrist	98	2
Psychologist	97	3
Social Worker	97	3
Spiritual healer	96	5
Counselor	95	5
Nurse	95	5
Traditional healer/medium	91	9
Minister/imam/clergy	82	18
Friends	70	30
Family member	70	30
Medical doctor	51	49
Other	__	14

Multiple Regression Analyses

One multiple regression analysis was conducted to predict West African immigrants' attitudes toward seeking psychological help as measured by the total scores on ATSPPH, using the BAS, BSI, and MHLO scores as predictors. The results of this analysis identified the total score of the MHLO as the only significant predictor of ATSPPH, accounting for 34% of the variance in ATSPPH total scores, adjusted $R^2 = .34$, $F = 18.39$, $p < .001$.

Correlational Analyses

The results of the correlational analyses are presented in Table 3, which also includes the means and standard deviations of the variables. Analyses indicate that there was no significant relationship between degree of acculturation (BSA) and ATSPPH ($r = .098$, $p = .304$). However, acculturation was negatively correlated with attribution beliefs about mental health problems (MHLO; $r = -.199$, $p = .036$), and severity of self-reported problems (BSI; $r = -.270$, $p = .004$). Similarly, ATSPPH was found to be negatively correlated with attribution beliefs about mental health problems ($r = -.571$, $p < .001$) and with severity of self-reported problems ($r = -.250$, $p = .008$). Finally, severity of self-reported problems correlated with attribution beliefs about mental health problems ($r = .250$, $p = .008$).

Table 3

Correlations, Means, and Standard Deviations of Variables

Variable	1	2	3	4
1. ATSPPH	__	.09	-.25*	-.57*
2. BSA		__	-.27*	-.19**
3. BSI			__	.25*
4. MHLO				__
M	72.51	70.22	86.32	60.61
Mdn	73.00	73.00	81.00	62.00
SD	9.80	12.26	26.08	12.44
Range	59	73	130	74

Note. ATSPPH = Attitudes Toward Seeking Professional Psychological Help Scale. BSA = Behavioral Acculturation Scale. BSI = Brief Symptoms Inventory. MHLO = Mental Health Locus of Origin Scale.

* $p < .05$. ** $p < .01$.

Discussion

The results of this study indicate that West African immigrants indeed experience concerns with their mental health including worry about/missing family members, stress, anxiety, cultural conflicts in acceptable disciplining of children, pressure/cultural conflicts in acceptable choices of mate, depression, nightmares, and gender and intergeneration conflict within families. They also reported concerns with their physical health, including stomach problems and headaches. In general, the findings revealed that West African immigrants of this study stated they would seek some kind of help for various problems. However, they clearly preferred medical doctors regarding physical health concerns, and family, friends, and clergy over psychological helping agents for social and emotional issues. By overwhelmingly endorsing the above resources, West African immigrants are expressing their preferences for the use of informal systems of support to resolve their emotional concerns. This is consistent with findings from previous studies which state that in many African countries, personal difficulties are usually discussed only within family unites (Darman et al., 2001).

Previous research with West African immigrants (e.g., Essandhoh, 1992) revealed that within the West African community, an individual with mental health problems would possibly consider it more appropriate to talk to someone from his/her social network, such as an elder in the community or a minister, rather than a mental health professional. West African immigrants may experience shame regarding needing help for psychological problems, resulting in their denial of some problems. This seems consistent with the present study, as 88% of respondents reported “no problems.” The finding that West African immigrants preferred informal social support and medical doctors to mental

health professionals raises important questions about the quality and type of help they receive. Although family, friends, and clergy serve as important sources of support, they are not trained to provide help for severe mental health problems. Thus, turning to informal social support is not always appropriate, and may place West African immigrants at risk.

The respondents were not asked about their reasons for not seeking professional help; however, there are several possible explanations: (1) West African immigrants' inability to identify problems for which they can get professional psychology help, and lack of information and skills for getting the help they need; (2) concerns about confidentiality; and (3) seeking help confirms the sense that there is a "problem," which arouses shame, embarrassment, and anxiety, particularly when it is an emotional problem.

Another obstacle to seeking help may be the respondents' perceptions that psychological professionals cannot provide them with the help they need. West African immigrants may believe that mental health care practitioners may lack knowledge and skills pertaining to their particular emotional needs. An interesting finding in the present study was that only a small percentage of respondents (1%) reported that they would turn to counselors, psychologists, psychiatrists, or social workers for help.

Research suggests that stigma may impede people from seeking or fully participating in mental health services. In particular, the threat of social disapproval within one's community or diminished self-esteem that accompanies the label may account for underused services. Advocacy and government groups have strongly endorsed resolving the stigma of mental illness as a way to improve service use

(Corrigan, 2004). The report of President Bush's New Freedom Commission highlighted anti-stigma programs as a primary goal to improve the mental health system (Hogan, 2003; Corrigan, 2004). A better understanding of the problem of stigma is needed to inform the development of these anti-stigma programs. Psychologists who are able to embrace this research agenda will help advocates to better tackle the stigma problem and will significantly advance treatment use in turn (Corrigan, 2004).

In addition to stigma, poor treatment adherence (i.e. quality of treatment) may be another factor negatively impacting West African immigrants' attitudes toward seeking professional psychological help. Consumer advocates (Chamberlin, 1978; Deegan, 1990) and researchers (McCubbin & Cohen, 1996; Rappaport, 1987) have argued that many psychosocial and medical treatments disempower people. As a result, people in need decide to not fully participate in services. People with mental illness who self-stigmatize tend to report little personal empowerment in terms of treatment and hence participation in treatment is diminished (Corrigan, 2004). As a result, interventions that challenge self-stigma and facilitate empowerment are likely to improve adherence (Speer, Jackson, & Peterson, 2001). Psychologists must be able to recognize what adherence means in this context; not blind compliance with whatever the therapist prescribes, but active participation and engagement in all aspects of care (Corrigan, 2004). Consumer operated self-help services are among the best examples of practices that facilitate empowerment (Davidson et al., 1999).

The regression results revealed that higher acculturation into the U.S. society, as measured by the total scores of the BAS, and severity of self-reported problems, as measured by the total scores of the BSI, were not found to be predictor variables of

attitudes toward seeking professional psychological help, as measured by the total scores of the ATSPPH. These results go against the hypothesis that West African immigrants' degree of acculturation and their self-reported symptoms of psychological distress would predict their attitudes toward seeking professional psychological help for their mental health distress. Although acculturation and severity of distress were not significant predictors for attitudes toward seeking professional psychological help for mental health distress, the findings provided some support for one part of the present study's hypothesis. Specifically, results revealed that only attribution beliefs about mental health problems, as measured by the MHLO was the only significant predictor of attitudes toward seeking psychological help.

This finding suggested that West African immigrants' attitudes toward seeking professional psychological help for mental health distress is most likely to be affected by cultural and traditional beliefs about mental health problems. This finding indicates the strength of the values and beliefs of the more traditional West African culture. It is to be expected that West African immigrants with more beliefs which focus on interactions between an individual and the social environment, as measured by the MHLO, would hold more positive attitudes toward seeking professional help for mental health problems. This seems to be supported by researchers (e.g., Hill & Bale, 1980) who argued that individuals who believe that the origin of mental health problems is located in one's interactions with the social environment may believe that any benefits to resulting from an encounter with mental health professionals requires an active involvement and acceptance of responsibility on the individual's part. Similarly, Hill and Bale argued that individuals who believe that mental health problems have a biological, inherited,

endogenous etiology will tend to expect the role of the client to be the relatively passive one of waiting for the "expert" to administer some mixture of advice, instructions, medication and the like. It seems that such individuals would be less likely to hold positive attitudes toward seeking professional help for mental health problems.

Correlational analyses were performed to clarify further the relationship of help-seeking attitudes to the predictor variables in the regression analyses. Results show that there was no statistically significant linear relationship between West African immigrants' level of acculturation and their attitudes toward seeking professional psychological help, and that there was also no linear association between their level of acculturation and their attribution beliefs about mental health problems. However, results indicated that West African immigrants' attribution beliefs about mental health problems had a linear association with their attitudes toward seeking professional psychological health for their mental health distress. Correlational results further revealed that greater perceived severity was negatively associated with attitudes toward professional psychological help-seeking. Finally, results indicated that greater perceived severity was associated with West African immigrants' level of acculturation.

These results support the assertion of many theorists (Marsella & White, 1982; Weiss et al., 1986; Eisenbruch, 1990) that non-Western cultures (in this case West African cultures) have a different conceptualization of mental health distress from Western cultures. Further research is needed to investigate the conceptions of mental distress of West African immigrants in the U.S. Future research should seek a more representative sample of West African immigrants to the U.S. If such research supports the association between the causal beliefs of mental distress and attitudes toward seeking

professional psychological help, it may help to illustrate ways of developing and providing more culturally appropriate services for this ethnic minority group in the U.S.

Findings of this study provide unique contributions to the field of psychology. It is one of the few studies highlighting the African born population in the psychology literature. Specifically, this study is one of the few studies focusing on West African immigrants in the U.S. and the impact of migration on their mental health and their ability and willingness to seek traditional Western care. This current study is one of the few studies on attitudes toward seeking psychological help for West African immigrants in the U.S. A major problem with the limited studies done on African immigrants is that they are restricted to student populations (e.g., Essandhoh, 1992). Respondents of the current study were recruited from the community rather than from university or college campuses.

Limitations of the present study included the use of self-report instruments to assess the variables and answer research questions. As with any survey or self-report measure, the questionnaire data may be prone to recall error and selective reporting. The extent to which the differences reported are indeed real, as opposed to reflecting only cultural differences, is unknown. The self-reported measures used in this study have generally been found valid for U.S. populations. However, the validity of these measures for West African immigrants has not been established.

Another methodological challenge was to procure representative and adequately sized West African immigrant sample. Participants were recruited during social gatherings, snowball methods, through use of representatives, and via email. This research procedure can be viewed as an adequate compromise between methodological

rigor and practical feasibility. This study yielded a 21% response rate of the target population, which is relatively small. Non-response can certainly affect the generalizability of the findings, and future research should, therefore, attack the complex issue of nonparticipation in mental health research with West African immigrants. The central question in this respect should concern the characteristics of the people who were not accessed for participation; and different sampling techniques should be utilized in order to obtain more participants.

Western Africa is a region of the continent with 16 countries. The diversity is not only in terms of geography but also in terms of history (different colonial experiences), culture, and language. It appears to be a serious generalization if all West African immigrants are put together and written about as if these differences do not exist. These ethnic differences were not used as variables to discriminate among the variables of this study. Results of the current study revealed that 9% of respondents sought traditional healer; which a little higher than expected. It seems important to examine how social desirability may be a factor and implications for these findings.

Another limitation is that this research did not investigate the help-seeking behaviors of West African immigrants, but rather their attitudes. Caution must be utilized in not expecting that behavior is synonymous with attitudes. Despite these limitations, this study has certain strengths. It is one of the few studies aimed at exploring West African immigrants' attitudes toward seeking professional psychological help. Also this seems to be the first investigation to attempt to recruit West African immigrants from the four major regions of the U.S.

Yet another limitation is that the study's sample size consisted of an overrepresentation of professionals with high levels of income. Specifically 14% of respondents received some 4-year college, 20% 4-year college, 10% some graduate/professional school, and 37% graduate/professional school. In terms of Social Economic Status (SES), the majority of respondents (34%) reported a total household income of 70,000 or more, followed by 9% $60,000 - $69,999, next 9% $50,000 - $59,999, and 15% $40,000 - $49,999. It seems likely that visa issues may be related to the self-selection process of these respondents. Specifically, U.S. immigration laws have made it easier for professionals and business executives who can prove financial sufficiency to qualify for entry into the U.S. while making it more difficult for unskilled workers such as domestic workers. These factors may help better explain the reason for the overrepresentation of respondents in the current study who have are professionals with higher SES and the underrepresentation of domestic workers with lower SES statues. It seems that these factors should be taken into consideration when interpreting the current findings.

A final limitation is that most of the respondents came from 3-4 countries; specifically 33% of respondents were from Ghana, Niger, 22%, 21% Mali, and 6% from Sierra Leone. It seems possible that an increased rate of respondents from other West African countries could impact the current findings.

Practical Implications

Findings of this study hold important practical implications for psychologists. Findings provide empirical support for the need to assess sociocultural variables when working with West African immigrant clients, particularly for their potentially different

impact on psychological help-seeking attitudes. If such research supports the association between the causal beliefs of mental distress and attitudes toward professional psychological help, it may help to illustrate ways of developing and providing more culturally appropriate services for West African immigrants in the U.S.

Findings suggest that West African immigrants' utilization of informal systems of support may make them feel less vulnerable than if they were to seek help from psychologists or other mental health professionals. Practitioners could intensify their outreach services to West African immigrants through medical doctors and through the aforementioned informal support systems. They could, for example, offer free seminars that target specific needs of West African immigrants (e.g., stress management seminar). Additionally, the possibility of offering more practical help (e.g., with administration problems concerning social services) and concrete solutions for material problems (e.g., housing problems and financial needs) would enhance the quality of care. Once credibility is established, West African immigrants may feel safer to use mental health services. These efforts would provide opportunities for psychologists to become more visible in West African communities, such that West African immigrant clients in need of psychological services might be more willing to seek professional help. Finally, it is reasonable to suggest based on the findings that group therapy with other West African immigrants may be a less non-threatening mode of therapy than individual psychotherapy.

To reduce the stigma of receiving mental health care treatment, mental health policymakers should design "attitude change programs," and develop "information campaigns" on the services offered by the U.S. mental health system (Knipscheer &

Kleber, 1999). These efforts could address certain prejudices and misconceptions about the U.S. mental health system. Recently migrated West Africans, and those with lower degrees of education in particular, could benefit from this information because they may be less willing to consult the services. In addition to the prevention programs, psychoeducational interventions should be considered, because these have been shown to be effective in reducing stigma (Knipscheer & Kleber, 1999).

Moreover, training more psychologists and other mental health professionals who are familiar with West African values and customs may help change perceptions of mental health agencies as being predominately American-oriented. This might help change both attitudes and behaviors among West African immigrants toward professional psychological help-seeking.

Research Implications

Larger samples of West African immigrants may be used to validate the present findings. Future research should address the critical issues of the validity and reliability of using standardized Western questionnaires with immigrant populations. Although the satisfactory estimates of internal consistency for the subscales offered some evidence for the reliability and validity of the data collected in the present study, it is still not clear whether well-known structured questionnaires and instruments are suitable to assess the mental health problems of immigrants to the U.S. There is evidence that the instruments developed in Western societies can be used with ethnic minorities as long as the interpretation is done with utmost care (e.g., Havenaar, Poelijoe, Kasyanenko, van den Bout, & Koeter, 1996; Knipscheer & Kleber, 1999; Shrestha et al., 1998). The degree of intercultural validity appears to be reasonable when culture-specific changes are allowed

and standardized measures are accompanied by more qualitative measures. Future research should, therefore, involve clinical assessment and observation of health issues and problematic behavior as well. The use of different instruments and different sources of information (a “multi-method, multisource research approach”) can only strengthen the findings of empirical studies in cross-cultural settings (Knipscheer & Kleber, 1999). Furthermore, future researchers should investigate the main antecedents that impact health and help-seeking behavior in the present study (gender, education, age, length of stay). Future research should also focus on the factor of ethnicity, because further differentiation within West African immigrants seems relevant. Finally, future research is needed to investigate the conceptions of mental distress of the increasing number of West African immigrants residing in the U.S.

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APPENDIXES

APPENDIX A

LETTER TO PARTICIPANTS

November 2007

Dear Fellow West African Immigrant:

I am originally from Mali, and a doctoral student in the Department of Counseling and Psychological Services at Georgia State University. I am conducting research for my dissertation to study West African immigrants' attitudes towards seeking psychological help. The results of this study will be used to further our understanding of experiences of West African immigrants' living in the United States in the hopes of enhancing our community.

Thank you very much for your participation in this study. **Please fill out this survey only if you are at least 18 years old and you are a West African immigrant currently living in the U.S**. There is no consent form: returning the research packet implies your consent to participate. Your responses and participation in this research are completely voluntary and anonymous. Any information obtained in connection with this study will remain anonymous. The **data** will be summarized and **reported in a group form only**. **Please return the completed survey in the attached pre-paid stamped envelope**.

There are no known risks to your health and well-being that might be related to your participation in this research. However, if you do feel uncomfortable, you can do any of the following: you can choose not to answer certain questions; 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. You will be responsible for all costs associated with seeking mental health services. A referral list of national mental health services is provided on the last page of the survey.

However if choose to continue, please do not leave any statements unmarked in order for the data to be meaningful.

If you have any questions about this research project, please call me, Damafing Keita Thomas: (865) 951-1276 or (865) 974-2196 or email: dthomas17@gsu.edu or my advisor, Dr. Yiu-Man Barry Chung: (404) 413-8202 or email: bchung@gsu.edu.

Thank you in advance for your cooperation.

Sincerely,

Damafing Keita Thomas

Damafing Keita Thomas, M.A., LPC, NCC
Counseling Psychology Doctoral Candidate
Georgia State University
Doctoral Intern
The University of Tennessee-Knoxville

APPENDIX B

PARTICIPANT INFORMATION SHEET

Directions:

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

1.)There are no right or wrong answers, please be OPEN and HONEST.

2.)Some statements may depict situations that you have not experienced; please imagine yourself in those situations when answering those statements.

3.)The entire questionnaire should take approximately 45-60 minutes to complete.

4.)Please return the completed questionnaire in the envelope provided (pre-paid postage included).

APPENDIX C

RESEARCH SURVEY

Anonymous Survey for West African Immigrants

Part 1 (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 get over 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. (Choose one)
   ( ) 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 counseling center. (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. 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. (Choose one)
    ( ) 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 own 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 (Behavioral Acculturation Scale (BAS); Szapocznik et al., 1978)

Instructions: For the following questions, please circle the number that best corresponds to your answer. If the question does not apply to you, please continue to the next question.

1	**West African all the time**
2	**West African most of the time**
3	**West African and English equally**
4	**English most of the time**
5	**English all the time**

What language do you prefer to speak?	**1**	**2**	**3**	**4**	**5**
What language do you speak at home?	**1**	**2**	**3**	**4**	**5**
What language do or did you speak at work?	**1**	**2**	**3**	**4**	**5**
What language do you speak with friends?	**1**	**2**	**3**	**4**	**5**
In what language are the T.V. programs you watch?	**1**	**2**	**3**	**4**	**5**
In what language are the radio stations that you listen to?	**1**	**2**	**3**	**4**	**5**
In what language are the books and magazines you read?	**1**	**2**	**3**	**4**	**5**

1	**West African all the time**
2	**West African most of the time**
3	**West African and English equally**
4	**English most of the time**
5	**English all the time**

What sort of music do you listen to?	**1**	**2**	**3**	**4**	**5**
What sort of dances do you dance?	**1**	**2**	**3**	**4**	**5**
What sort of places do you go out to?	**1**	**2**	**3**	**4**	**5**
What sort of recreation do you engage in?	**1**	**2**	**3**	**4**	**5**

1	**West African all the time**
2	**Mostly West African**
3	**Mixed: sometimes West African times and others American**
4	**Mostly American**
5	**Completely American**

My way of celebrating birthdays is	**1**	**2**	**3**	**4**	**5**
My way of relating to my spouse/significant other is….	**1**	**2**	**3**	**4**	**5**
The gestures I use in talking are……	**1**	**2**	**3**	**4**	**5**

1	**I would wish this to be completely West African**
2	**I would wish this to be mostly West African**
3	**I would wish this to be West African and American**
4	**I would wish this to be mostly American**
5	**I would wish this to be completely American**

Food…	**1**	**2**	**3**	**4**	**5**
Language…	**1**	**2**	**3**	**4**	**5**
Music…	**1**	**2**	**3**	**4**	**5**
T.V. programs…	**1**	**2**	**3**	**4**	**5**
Books/Magazines…	**1**	**2**	**3**	**4**	**5**
Dances…	**1**	**2**	**3**	**4**	**5**
Radio Programs…	**1**	**2**	**3**	**4**	**5**
Ways of Celebrating Birthdays…	**1**	**2**	**3**	**4**	**5**
Ways of Celebrating Weddings…	**1**	**2**	**3**	**4**	**5**

Part 3 (Brief Symptom Inventory (BSI); Derogatis, 1975)

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Part 4 (Mental Health Locus of Origin Scale (MHLO); Hill & Bale, 1980)

Instructions: This questionnaire is intended to measure people's attitudes about mental health problems. Please read each statement carefully and indicate your agreement or disagreement with each of the following statements. There are no right or wrong answers. Please do not leave any statement unmarked.

1. Eventually medical science will discover a cure for psychosis (Choose one)
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

2. The cause of most psychological problems is to be found in the brain.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

3. If the children of schizophrenics were raised by normal parents they would probably grow up to be mentally healthy.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

4. Mental illness is usually caused by some disease of the nervous system.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

5. Some people are born mentally unstable and are almost certain to spend some part of their lives in mental hospital.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

6. Most people suffering from mental illness were born with some kind of psychological deficit.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

7. Some people are born depressed and stay that way.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

8. Everybody's system has a breaking point and those of mental patients are probably weaker.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

9. The mental illness of some people is caused by the separation or divorce of their parents during childhood.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

10. Being hot-blooded is the cause of mental illness in some people.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

11. More money should be spent on discovering healthy methods of child rearing than on determining the biological basis of mental illness.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

12. Some people are born with the kind of nervous system that makes it easy for them to become emotionally disturbed.

( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

13. Your choice of friends can have a lot to do with your becoming mentally ill.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

14. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

15. Some people are born with a slightly greater capacity than others to commit suicide later in life.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

16. Many normal people would become mentally ill if they had to live in a very stressful situation.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

17. Mental health professionals probably underestimate the extent to which brain damage is responsible for mental illness.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

18. When a group of people are forced to live under extremely stressful conditions the ones who crack under the strain are likely to be the ones who inherited a psychologically weak disposition.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

19. The kind of nervous system you are born with has little to do with whether you become psychotic.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

20. The cause of many psychological problems is bad nerves.
( ) 1 Strongly Disagree ( ) 2 Moderately Disagree ( ) 3 Slightly Disagree
( ) 4 Moderately Agree ( ) 5 Strongly Agree

Part 5 (DEMOGRAPHIC QUESTIONNAIRE; Damafing Keita Thomas)

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 Martial 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) Guinée

_____ (6) Guinée-Bissau

_____ (7) Gambia

_____ (8) Liberia

_____ (9) Mali

_____ (10) Mauritania

_____ (11) Niger

_____ (12) Nigeria

_____ (13) Sénégal

_____ (14) Sierra Leone

_____(15) Togo

_____ (16) Cape Verde

5. In what U.S. state 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? (Please check one):

_____ (1) Elementary school

_____(5) Some college

_____ (2) Some High School

_____(6) Bachelors or four year degree

_____ (3) High School Diploma

_____ (7) Some graduate/professional school

_____ (4) Associate or two year degree

_____(8) Graduate or professional degree

8. 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? _____

year(s) _____ month(s)

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

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

_____ (1) Under $10,000

_____(5) $40,000-$49,999

_____(2) $10,000-$19,999

_____(6) $50,000-$59,999

_____(3) $20,000-$29,999

_____(7) $60,000-$69,999

_____(4) $30,000-$39,999

_____(8) $70,000 or more

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

_____ day(s) _____ week(s)

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

_____ (1) depression

_____ (2) stress

_____ (3) anxiety

_____ (4) headaches

_____ (5) social isolation

_____ (6) worry about/missing family members

_____ (7) stomach problems

_____ (8) cultural conflicts in acceptable disciplining of children

_____ (9) pressure/cultural conflicts in acceptable choice of mate

_____ (10) war trauma

_____ (11) voyage trauma

_____ (12) gender and intergenerational conflict within families

_____ (13) nightmares

_____ (14) other physical problems (please write in)

_____ (15) other mental health problems (please write in)

16. Who do/did you contact for this/these problem(s)/concern(s)?

_____ (1) psychiatrist

_____ (2) psychologist

_____ (3) social worker

_____ (4) counselor

_____ (5) minister/imam/clergy

____ (6) spiritual healer

_____ (7) traditional healer/medium

_____ (8) friends

_____ (9) family member

_____ (10) medical doctor

_____ (11) nurse

_____(12) other (please write in)

APPENDIX D

Referral List for Mental Health, Counseling and Crisis Services

There are no known risks to your health and well-being that might be related to your participation in this research. However, if you do feel uncomfortable, you can do any of the following: you can choose not to answer certain questions; 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. You will be responsible for all costs associated with seeking mental health services.

Please see below a referral list of 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 Numbers

Depression and Bipolar Support Alliance- 1-800-826-3632
National Mental Health Association- 1-800-969- 6642 (M-F 9-5 EST)
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