MENTAL HEALTH HELP-SEEKING BEHAVIOUR: 
AFRICAN IMMIGRANTS’ EXPERIENCE

by

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Abstract

The purpose of this study was to explore the help-seeking behaviour of African immigrants in Ottawa, Ontario. One of the greatest challenges to effective intervention for prevention and treatment of mental health disorders is the reluctance of people to seek professional mental health care. The mental health help-seeking behaviour of African immigrants has not been explored in mental health research in this country. In addition, very little has been written regarding specific cultural concepts in the worldview of this group of people and how this perspective impacts their help-seeking behaviour. In this study, existing research is reviewed and incorporated into a foundation for understanding African immigrants’ perception of mental health. Method: Eight self-identified African immigrants were interviewed. Interviews were transcribed and analyzed using content analysis. The findings from this study indicated there are hindrances to help-seeking behaviour for this group of the population, such as language barriers, cultural differences, stigma, loneliness, and lack of social support networks.

Future studies may focus on strategies to evaluate and examine existing programs serving new immigrants as they navigate through the healthcare system.
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# Table of Contents

Abstract ............................................................................................................................................. ii  
Acknowledgements ............................................................................................................................... iii  
List of Tables ....................................................................................................................................... viii  
List of Figures ..................................................................................................................................... ix  
Chapter 1: Introduction ......................................................................................................................... 1  
  Significance of the Study ....................................................................................................................... 2  
  Declaration of Personal Interest ............................................................................................................. 3  
  Conceptual Framework of Stress and Coping ......................................................................................... 4  
Chapter 2: Literature Review .................................................................................................................. 7  
  Introduction ........................................................................................................................................ 7  
  Immigrants’ Mental Health ..................................................................................................................... 7  
  Patterns of Mental Health Services Utilization ..................................................................................... 9  
  Factors Associated with the Development of Mental Health Problems ............................................. 11  
    Unemployment and low income ........................................................................................................... 11  
    Acculturative stress ............................................................................................................................... 12  
    Lack of family and social support network ......................................................................................... 13  
  Cultural Concepts and Mental Health ............................................................................................. 16  
  Barriers to Seeking Professional Help and Services Utilization ...................................................... 18  
    Stigma ............................................................................................................................................. 19  
    Economic barriers .............................................................................................................................. 21  
    Lack of appropriate services ............................................................................................................. 21  
    Lack of awareness ............................................................................................................................... 22  
    Diagnosis and treatment of mental health disorders in Africa ....................................................... 23  
    Traditional medicine ......................................................................................................................... 23  
    Faith and churches ............................................................................................................................. 25  
  Purpose of the Study ............................................................................................................................ 26  
Chapter 3: Method ................................................................................................................................. 28  
  Research Design and Analysis ............................................................................................................... 28  
    Respondent numbers .......................................................................................................................... 29  
    Recruitment of respondents ............................................................................................................. 30
Chapter 4: Presentation of Findings ................................................................. 38

Demographic characteristics. ........................................................................... 38

Theme Identification ......................................................................................... 38

Respondents’ Views on Mental Health ............................................................ 40

Mental illness appraised as a threat. ............................................................... 41
   i) To be feared .............................................................................................. 41
   ii) Crazy ..................................................................................................... 42
   iii) Right mind ............................................................................................ 42

Respondents’ thoughts on causes of mental illness ....................................... 43
   i) Supernatural causes .............................................................................. 43
   ii) Negative thoughts .............................................................................. 43
   iii) Stress related ...................................................................................... 44
   iv) Family role strain .............................................................................. 45
   v) In Canada mental health is normalised .............................................. 45
   vi) Country of origin discrimination and negative perception ............... 46

Mental Health Resources ............................................................................... 46

Social/Environmental resources .................................................................... 46
   i) Lack of knowledge about resources .................................................. 47
   ii) Lack of trust ......................................................................................... 47

Resettlement and its challenges ..................................................................... 48
   i) Why am I here. ..................................................................................... 48
   ii) Canada, land of opportunity .............................................................. 49
   iii) Loneliness ......................................................................................... 49
   iv) Language barriers ............................................................................. 50

Cultural appraisal ............................................................................................ 50
i) Stigma................................................................................................................. 51
ii) Taboo. .................................................................................................................. 51
iii) Gender expectation of strength......................................................................... 52

Positive Coping Strategies ....................................................................................... 52
  Emotion-focused coping.......................................................................................... 53
    Taking care of emotional/social self................................................................. 53
  Problem-focused coping......................................................................................... 57
    Taking care of physical body and self............................................................... 57

Summary of Findings................................................................................................. 59

Chapter 5 .................................................................................................................. 60
  Discussion of Significant Findings......................................................................... 60
  Concept of Mental Health/Illness ........................................................................... 60
  Mental Health Help-seeking Behaviour .................................................................. 61
  Cultural Appraisal .................................................................................................. 63
  Stigma .................................................................................................................... 64
  Resources .............................................................................................................. 64
  Coping Responses ................................................................................................. 66
  Personal Resources............................................................................................... 67
  Implications for Future Research .......................................................................... 68
  Implications for Nursing Practice and Policy Makers ........................................... 68
    Limitations.......................................................................................................... 70
  Conclusion .............................................................................................................. 71

References ................................................................................................................ 72

APPENDIX A: Flyer to Advertise Study and Recruit Participants from the African Community ................................................................. 86

APPENDIX B: Consent to Participate as a Research Subject ...................................... 87

APPENDIX C: Demographic Sheet ............................................................................ 91
List of Tables

Table 1: Demographic Characteristics of Participants .......................................................... 38
List of Figures

Figure 1: Concepts and Themes .................................................................................................................. 39
Chapter 1: Introduction

According to data from the 2011 National Household Survey, Canada had a total of about 6,777,800 foreign born individuals who had arrived as immigrants (Statistics Canada, 2011). They represent 20.5% of the total population, compared with 19.8% in the 2006 census. Between 2006 and 2011, about 145,700 immigrants arrived from Africa, representing 12.5% of newcomers who arrived during the previous five-year period. Whereas immigrants used to come exclusively from Europe, 58.3% now come from Asia, 16.1% come from the Middle East and Europe, and 12.3% come from the Caribbean, Central and South America (Statistics Canada, 2011).

As these groups of immigrants become part of Canadian society, there is a great need to understand how these individuals and families adapt to life in Canada. Immigration involves three major sets of transitions: change in personal ties and reconstruction of social networks, a move from one social-economic system to another, and a shift from one cultural system to another (Bhugra, 2004). New African immigrants face considerable challenges in their new host country. Disillusionment, demoralization, and depression can occur early as a result of migration-associated losses, or later, when initial hopes and expectations are not realized (Bhugra, 2004). Also, immigrants and their families may face enduring obstacles to advancement in their new home because of systemic barriers and inequalities, aggravated by policies, racism, and discrimination (Noh, Kaspar, & Wickrama, 2007). Research found that compared to native born Canadians, immigrants have less access to basic and preventative health services, family doctors, or consultation with medical specialties (Chen & Kazanjian, 2005). On the other hand, underutilization of preventative health services may be interpreted as a reflection of the inadequacy of existing services in meeting immigrants’ needs (Hyman, 2004).
The difficulties associated with settling in a new country are likely to affect the mental health of new immigrants. Reports on healthcare services utilization by immigrants are inconsistent. Some studies suggest that immigrants as a whole underutilize healthcare services, compared to the Canadian born population (Globerman, 1998) while other studies report that immigrants use health services as much as, or even more than, Canadian born populations (Blais & Maiga, 1999; Wen, Goel, & Williams, 1996). Nevertheless, most Canadian studies report lower utilization, particularly among non-European immigrants who are under-represented in all forms of healthcare services use, including hospital services, emergency room visits, dental care services, mental healthcare services, and preventive healthcare services provision (Chen & Kazanjian, 2005; Globerman, 1998). Empirical research that specifically describes the help-seeking behaviours, rates, and patterns of healthcare services use by African immigrants is limited. This study aims to understand the experience of African immigrants in seeking help for their mental, emotional, and perception of mental health problems.

**Significance of the Study**

As immigrant populations continue to grow, the health of this group will be reflected increasingly in the overall health status of Canada, thus making it even more critical to monitor immigrants’ health in general and their mental health in particular. The total estimated economic burden of mental illness in Canada is about $851 billion, including both direct and indirect costs and losses in health-related quality of life (Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008). This makes mental health a costly issue in Canada. The healthy immigrant effect is well documented in scientific literature; past studies on immigrant health mostly found a health advantage among immigrants to Canada, possibly as a result of strong selection factors (Chen, Wilkins, & Ng, 1996). The findings are similar for immigrants' mental health though its
trajectory is less clear. However, these studies also found a loss in this advantage over time in several standard health measures, including self-reported health (Chen et al., 1996; Newbold & Danford, 2003). Previous research on immigrant mental health in Canada, however, had found that immigrants experienced higher levels of psychiatric disorders, depression, and substance abuse (Newbold & Danford, 2003). Though immigrants may be relatively healthy upon arrival in their new host country, barriers to health care may lead to missed opportunities for medical intervention, increased health risk, and high costs of treatment later on (Newbold & Danford, 2003).

There is an increase in studies and literature that pertains to immigrant and refugee mental health, however they tend to focus largely on social determinants, the rate of mental illness, and barriers and enablers of services (Hansson, Tuck, Lurie, & McKenzie, 2010). The mental health of African immigrants living in Canada is unknown. Moreover, experiences in Canada may affect an African immigrant’s mental health. Studying the help-seeking behaviour of African immigrants is therefore important for identifying potential impacts on the healthcare system, as well to understand how immigrants fare once they start living in Canada and whether they are seeking help for their emotional and psychological issues. To meet the mental health needs of ethnic minority populations, insight into help-seeking behaviour is of great value. Help-seeking pathways provide the critical link between the onset of psychiatric problems and the provision of mental health care.

**Declaration of Personal Interest**

The current research proposal was developed in response to my own personal experience as a new African immigrant when residing in Germany. It was my first experience living abroad.
I hail from a big extended family and we are extremely close-knit. We all grew up in the same region of the country, thus travelling to a new country and leaving that comfort zone was a very stressful experience for me. The most challenging aspects were the language barrier, culture shock, and loneliness. A visit to a grocery store was a nightmare since I didn’t know, for example, what sugar was called in Germany. I would approach people to ask whether they spoke English but the answer was “nay,” which means no. Occasionally I would get up in the morning with a headache and a lot of discomfort. A visit to a doctor was not any different as I also needed a translator there. After several visits to a doctor and many diagnostic tests, there was no diagnosis of my condition. Then I went for a counseling session, and realized that I was suffering from psychological stress. Luckily we moved to Canada. I must admit that was a breakthrough, not in the sense that it was so much better, but at least I did not need a translator. When I joined the nursing programme, my own experience inspired me to carry out research on new African immigrants regarding whether they are able to seek help for their psychological and emotional issues as they navigate through the healthcare system.

**Conceptual Framework of Stress and Coping**

It has been postulated that individuals who experience a number of stressful events are at increased risk for developing physical and psychological illness (Billingsley, 1992; Lloyd, 1980; Locke, 1992). African immigrants in this study compose a group that has been exposed to a range of stressors over time. The Transactional Model of stress and coping (Lazarus & Folkman, 1984) provides an overarching theoretical framework for the study. The model posits that how people appraise the environment has a direct impact on their mental health, as well as their choice of coping strategies, which in turn affects mental health (Lazarus & Folkman, 1984). The cognitive theory on which this study is based describes psychological stress and coping within a
transactional context, in that person and environment are viewed as being in a dynamic, mutually reciprocal and bidirectional relationship. Stress is conceptualized as a relationship between the person and the environment (Lazarus & Folkman, 1984). The theory identifies the two processes of cognitive appraisal and coping as critical mediators of a stressful person-environment relationship and their immediate and long-term outcomes. The present study explored stress in relation to mental and emotional problems among the respondents. The investigator interviewed respondents about the emotional and psychological stress they encountered and how they overcome it. The respondents were able to describe the ways they coped with stressful demands. The results also provide strong evidence that coping is indeed a significant mediator of emotional response to actual stressful encounters.

Cognitive appraisal is a process through which a person evaluates whether a particular encounter with the environment is relevant to his or her well-being and, if so, in what way (Lazarus & Folkman, 1984). There are two kinds of cognitive appraisal: primary and secondary. In primary appraisal, a person evaluates whether anything is at stake in this encounter. In secondary appraisal, the person evaluates his or her resources and determines what can be done to overcome or prevent harm or improve the prospect of benefit. This is in line with the findings of this study regarding help-seeking behaviour, in that some respondents opted to find help while others took to other measures to alleviate the emotional and psychological stress they were experiencing.

Coping is intimately related to the concept of cognitive appraisal and, hence, to stress-relevant person-environment transactions. Coping refers to a person’s cognitive and behavioural effort to manage the internal and external demands of the person-environment transaction that is appraised as taxing or exceeding the person’s resources (Lazarus & Folkman, 1984). Coping
strategies are usually categorized into problem- or emotion-focused (Lazarus & Folkman, 1984). Problem-focused coping strategies represent the active attempts people make to reduce the stress they face, whereas emotion-focused coping strategies are directed at regulating emotional problems and emotionally escaping from, or avoiding, stressful situations (Lazarus & Folkman, 1984). Problem-focused coping entails constructive action to change stressful situations, hence, some of the problem-focused strategies used by respondents in this study were diversion and distraction, counseling, and spirituality. The respondents also used emotion-focused strategies (informal coping), such as family, friends, and church. The findings from this study and other literature suggests that African immigrants tend to cope with mental health stressors by using informal resources, such as church, family, friends, and neighbours (Matthews & Hughes, 2001). Social support can facilitate an individual’s positive effort to cope, as illustrated by respondents in this study as they rely more on their friends and family for support. In sum, mounting evidence suggests that the coping process plays an important role in the process of attempting to manage the demands created by stressful events that are appraised as taxing or exceeding personal resources (Lazarus and Folkman, 1984). This provides strong evidence of how Lazarus’ stress and coping framework was useful in both the interview sessions and analysis section of this study. This framework has been shown to be effective in the development of questionnaires, such as the ones used in the study.

While the framework describes how stress can be modulated by a number of resources, little is known about the strategies or resources that are fundamental to optimize mental health.
Chapter 2: Literature Review

Introduction

Mental health is defined by the World Health Organization (WHO) (2001), as a “state of well being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” Mental illness consists of the interaction between the brain, psychology, and social environment which can lead to distressing thoughts, emotions, behaviours, and physical responses (WHO, 2001). Mental illness affects everyone at some point in time and it affects people of all ages, educational levels, income levels, and cultures (WHO, 2001). Worldwide about 450 million people are challenged by mental or behavioural disorders and about one million people commit suicide every year (WHO, 2003). Mental health research in Canada has found that the immigrant experience elevated levels of depression, substance abuse, and other psychiatric disorders, at least in the period soon after immigration (Beiser, Dion, Gotowiec, Hyman, & Vu, 1995).

Immigrants’ Mental Health

Resulting from centuries of immigration, Canada is a multicultural nation comprised of people from a wide range of ethnic and cultural heritages. Views of the mental health status of immigrants were based on the idea that as immigrants encountered hardships and obstacles while adapting to their new environment, they were at increased risk of developing mental health problems when compared with their Canadian counterparts (Newbold & Danford, 2003). Migration to a new country potentially is a disruptive and stressful experience; it can produce profound distress even among the best prepared (Newbold & Danford, 2003). difficulties in
connecting with and adapting to the economic and social institutions of the host country may result in poor mental health outcomes. As immigrants interact further with the environment and become more comfortable with it, the risk of developing poor mental health is expected to decrease over time (Newbold & Danford, 2003). Immigrants arriving in Canada may, therefore, report experiencing more stress and mental health problems when compared with their Canadian counterparts (Newbold & Danford, 2003). Conversely, a number of current empirical studies suggest that some immigrants may fare better than their Canadian counterparts when it comes to the question of mental health (Blais & Maiga, 1999; Newbold & Danford, 2003; Simich, Scott, & Agic, 2005).

In a community-based, mixed methods study of 220 recent Sudanese immigrants to Ontario, researchers examined the association between economic hardship, mental health, and expectations of life in Canada. The researchers found that individuals who were experiencing economic hardship were between 2.6 and 3.9 times as likely to experience loss of sleep, constant strain, unhappiness and depression, and bad memories than individuals who did not experience hardship (Simich, Hamilton, & Baya. 2006).

A recent screening of health problems among African immigrants in New York identified mental health concerns as one of the top three problems reported to community based organizations, in addition to medical concerns such as hypertension and diabetes (Venters et al., 2011). Despite these reports, discussion of mental illness, which is likely to be related to factors experienced prior to immigration, such as wars, famine, and separation from family members, is generally not broached among African immigrants and continues to be stigmatized within immigrant populations (Ward & Kennedy, 1993).
Patterns of Mental Health Services Utilization

In coping with life stressors, many people seek help to alleviate their stress through the use of mental health services. For those who choose to utilize mental health services, studies have shown that there is a significant benefit from the use of such services (Reay, Stuart, & Owen, 2003; Van Citters & Bartels, 2004). In general, Canadian minority group members use fewer mental health services than their non-minority counterparts (Munroe-Blum, Boyle, Offord, & Kates, 1989). Data in Canada have shown that immigrants and ethnic minorities are underserved in the mental healthcare system or are less likely to use mental health services (The Daily Statistic Canada, 2003). Kirmayer et al. (2007) conducted a study in Montreal, Canada on the use of healthcare services for psychological distress, with a random sampling of 924 Canadian-born individuals and 776 new immigrants. It revealed that the rate of health services use for psychological distress was lower among immigrants (5.5% compared to 14.7% for Canadian-born individuals). Fenta, Hyman, and Noh (2006) sought to examine the patterns of mental health utilization by Ethiopian immigrants and refugees residing in the Greater Toronto Area (GTA) and to identify factors associated with mental health service utilization. The researchers administered cross-sectional epidemiological surveys among 342 randomly selected male and female Ethiopian immigrants and refugees, aged 18 to 59, who had resided in Canada for less than 12 months. Data analysis consisted of both descriptive and multivariate methods of analysis. Among respondents with mental health disorders, 12.5% sought services from mainstream healthcare providers while 18.8% consulted non-health professionals, such as religious leaders, traditional healers, and other persons in the ethnic community. Of those with mental disorders who sought medical services, 10.5% saw a family physician, 4.3% visited a psychiatrist, and 2.2% consulted other healthcare providers. However, the researchers found
considerable mental healthcare needs in the Ethiopian community; the prevalence rate of mental disorders, particularly depression, was higher than the rate estimated for the Ontario population (Fenta et al., 2006). The researchers also found ample evidence that immigrants and refugees often receive culturally or linguistically inappropriate care or experience multiple barriers to care.

The authors explained that the low utilization rate of mental health services from the mainstream healthcare providers could also be attributed to the stigma attached to mental illness (Fenta et al., 2006). Participants in the study reported seeking services from family physicians for somatic symptoms such as chronic fatigue, tension headaches, and insomnia (Castillo, Waitzkin, Ramirez, & Escobar, 1995). Somatic symptoms are often considered to be an expression of psychological distress and individuals who report more somatic symptoms are more likely to have contact with the healthcare system (Castillo et al., 1995). The researchers’ findings shows that somatic symptoms are prevalent among Ethiopians in Toronto and lead to increased mental health service utilization, particularly that which is provided by family physicians. The authors recommended that family physicians could play an important role in identifying and treating Ethiopian clients who come to them with somatic symptoms, as these symptoms may reflect mental health problems (Fenta et al., 2006).

Mahon (1980) described several reasons for under-utilization of mental health services by African Americans. He noted that racial stereotypes, job discrimination, substandard patient care, insufficient treatment, more severe diagnoses, higher medication dosages, and discriminatory testing are some of the problems African Americans have encountered in seeking mental health services. Kleiner (1992) noted how people from non-Western cultures are unwilling to intimately confide in healthcare providers about their belief in the spiritual world and are unwilling to
openly criticize their families. Sue and Sue (1990) in their study, “Counseling the culturally different”, noted that physicians using a biomedical model assume clear distinctions between mental and physical health while, on the contrary, African cultures do not make a distinction between them.

Foreign-born Black Caribbean and Latino immigrants have been found to have markedly lower lifetime rates of psychiatric disorders than U.S.-born Black Caribbeans and Latinos (Polo & Lopez, 2009; Williams et al., 2007). Furthermore, first generation immigrants have been found to have better health, fewer conduct problems, and better academic achievements than their American counterparts (Motti-Stefanidi, Pavlopoulos, Obradovic, & Masten, 2008). First known as the “Hispanic Epidemiological Paradox” (Markides & Coreil, 1986), this outcome is now known as the “healthy immigrant effect.” This refers to findings that some immigrant groups tend to have fewer mental health concerns than individuals born in the United States. Speculation about the reasons why this effect is seen with recent immigrants has centered on the possibility that those who immigrate tend to be the “fittest” in the society and, therefore, tend to have better chances of survival in their country of residence (Escobar, 1998).

Factors Associated with the Development of Mental Health Problems

Unemployment and low income.

Historically, immigrants have been regarded as a secondary labour force and thus they experience unemployment or underemployment or both (Dossa, 2004). Difficulties in finding sustained employment can be linked to biases or discrimination related to the immigrant’s country of origin, language, skin colour and appearance, health status, and an undervaluing of foreign education and work credentials (Akhavan, Bildt, Franzen, & Wamala, 2004; Beiser &
Hou, 2001). Unemployment threatens mental health in two ways. First, unemployment is a very stressful experience accompanied by low self-esteem, social isolation, and family conflict that can further lead to mental illness (Shortt, 1996). Second, unemployed persons can adopt unhealthy coping strategies, such as smoking and alcohol or drug abuse, which can negatively impact mental health. Immigrants who are unemployed report poorer self-rated health, lower self-esteem, depression, and more anxiety than those who have an established employment (Shortt, 1996).

Acculturative stress.

According to Nwadiora and McAdoo (1996) acculturative stress is defined as “psychocultural” stress due to cultural differences found between the host culture and an incoming culture, signified by a decline in the physical and mental health status of individuals or groups undergoing acculturation. The development of acculturative stress and possible mental health problems in immigrants also seems to be related to the length of residence in the immigrants’ country of residence. In their study of acculturative stress among adult Latino immigrants, Miranda and Matheny (2000) found results indicating that Latino immigrants with longer residence in the United States reported experiencing fewer stress symptoms than recent immigrants.

This finding supports the proposed U-shaped health curve observed in immigrants to the United States by Rumbaut (1994). He noted that over a period of several years, the immigrant transitions between feelings of euphoria upon arrival, followed by disenchantment when one realizes a disconnect between expectations before residence and reality upon arrival, and finally, a return to original levels of well-being after one learns to deal with the challenges of
immigration. Upon immigrating, migrants are faced with challenges that they have to overcome in their new host culture. As previously mentioned, some have been able to successfully navigate this period of adjustment. Others, however, have had to struggle with this period of adjustment and the accompanying acculturative stress may have contributed to the development of mental health problems, such as anxiety and depression.

Lack of family and social support network.

The family and social support network of migrants can be an important source of support in the resettlement context and can promote mental well-being. Family is the cornerstone of African culture and consists of an extended family that includes one’s blood relatives from several generations (Kamya, 1997). African identity is rooted in the community identity: individuals are viewed as a part, or an extension, of the environment because of the belief that everything is functionally connected (Kamya, 1997). Many newcomers to Canada come from cultural backgrounds where family members are usually consulted about any health problems and accompany patients to visit the physician (Kamya, 1997). Immigration can stress and fragment families; close members might be left behind, sometimes in dangerous circumstances. The tendency to focus on the patient in primary care must be supplemented by close attention to the family system and social network.

Research findings reveal that immigrants tend to rely first and foremost on extended family members (especially those who have been in the country longer) for settlement related needs and also for a social support network (Khanlou, Shakya, & Muntaner, 2007–2009). An emerging body of research has also pointed to the role of extended kinship networks (family, friends, church members, fictive kin, and neighbours) in African American communities as
sources of informal help (Billingsley, 1992; Tucker & Lewis 1990; William & Cooper, 1999). Particularly when confronted with stressful situations, people of African descent have been noted to rely on family, community, and social networks (Daly, Jennings, Beckett, & Leashore, 1995). These extended social networks provide a variety of support, including instrumental and tangible aid, emotional supports, and sources of advice or information (Hatchett, Cochran, & Jackson, 1991). The specific needs of a potential immigrant, and the importance of extended family members, must also to be taken into consideration (Canadian Association for Community Living, 2005). Social support networks outside of the family tend to revolve around the ethnic community, and religious organizations that cater specifically to that ethnic community. Some mosques, for instance, while not formally connected to settlement programs, provide informal assistance to newcomers ranging from legal advice, to employment skills, to explanations of cultural differences (Khanlou et al., 2007–2009). The way in which “family” is defined in legislation may not always concur with the reality, while social support can mean different things to different people within communities. Simich, Scott, and Agic (2005) reported common forms of social support as identified by policy makers and service providers that include informational, instrumental, and emotional supports. In order to provide different levels and types of support, an attempt must be made toward holistic coordination of services (Simich et al., 2005).

The perceived impact of social support on the well-being of immigrant communities is also significant (Simich et al., 2005) and must be connected to the broader social determinants. Earlier studies found that the presence of a high level of social support is associated with reports of less physical and mental illness than when social support is low or not available (Gore, 1978; Porritt, 1979). Social support and access to social networks is a significant moderator of psychological distress and help-seeking behaviour among people of African descent.
(Constantine, Wilton, & Caldwell, 2003). Evident in the existing literature is that African Americans often rely on family members and other informal social supports to help address their concerns before seeking professional psychological help (Constantine, Chen, & Ceesay, 1997; Harris & Mollock, 2000).

Constantine, Wilton, and Caldwell (2003) conducted a survey to examine the role of social support networks in enhancing the relationship between willingness to seek psychological help and psychological distress. In this study, 157 Black and Latino college students were interviewed. The results revealed that African American immigrants were less likely to seek psychological help if they had a strong social support network. Similarly, Clay, Roth, Wadley, and Haley (2008) conducted a longitudinal study that examined the impact of social support on the psychosocial outcomes of 166 caregivers of dementia patients (African Americans [n=69] and Whites [n=97]). The researchers found that African American immigrant caregivers reported higher levels of satisfaction with social support, indicative of decreased levels of depressive symptoms and higher levels of satisfaction, than white caregivers. Some other research findings show that individuals with strong social support, as reflected in numbers of close friends and relatives accessible to them, are less likely to seek formal psychological services (Linn & McGranahan, 1980; Will, 1992), whereas those who lack sources of social support are more likely to seek professional mental health care for emotional concerns (Bosmajian & Mattson, 1980; Keller & Achter, 1995). Informal support impacts the help-seeking process by shaping how an individual evaluates and responds to distressing symptoms (Rickwood & Braithwaite, 1994). Alternatively, the decision to seek professional help may be influenced by individuals’ perceptions that they have a problem that they cannot manage individually or collectively with the assistance of their social support network. In the absence of benefits incurred by a strong
social support network, psychological distress may continue or intensify, which in turn increases the likelihood that professional psychological services will be sought (Rickwood & Braithwaite, 1994). For these reasons, the present study’s inclusion of African cultural coping behaviours will likely add a valuable dimension to models of seeking professional psychological help.

**Cultural Concepts and Mental Health**

It is well documented that culture influences how health is viewed, how symptoms of illness are experienced, and when and how help is sought (Fabrega, 1995; Kirmayer & Looper, 2006). Culture can profoundly influence every aspect of illness and adaptation, including: interpretations of illness and reactions to symptoms; explanation of illness; patterns of coping, seeking help and response; adherence to treatment; style of emotional expression and communication; and relationship between patients, their families and healthcare providers (Helman, 2007). Most of the literature speaks of the belief that non-Western culture adheres to a holistic understanding of health and lacks the concept of mind and body being divided (Raguram, Weiss, & Channabasavanna, 1996). A recent study of immigrant women from Africa in Nova Scotia (Weerasinghe & Mitchell, 2007) used focus groups to explore the concept of health and found that health was defined as having physical, social, and emotional aspects and none of the participants described health as being free of illness.

The practice of seeking help in order to address cultural adjustment difficulties and physiological or emotional distress further highlights the disparity of two cultures (African and Western), and poses more challenges to African immigrants. Across African communities the act of seeking professional psychological help carries different meanings in different cultures (Ponterotto, Fuertes, & Chen, 2000). For some, the process of seeking help may reveal one’s
inadequacy and dependency (Nadler, 2002) and others may feel uncomfortable to seek help in dealing with depression for fear of being labeled insane (Diginesh, 2006). A considerable portion of patients in primary care present their mental health problems in terms of physical complaints, making the correct diagnosis of mental disease challenging. Inadequate screening and evaluation could lead to under-recognition and treatment of common mental disorders (Kirmayer, 2001). Patients with depression or anxiety sometimes focus on physical symptoms or use culture-specific bodily idioms to express distress (Groleau & Kirmayer, 2004).

The assessment and treatment of mental health in African immigrants may be influenced by the way they express their symptoms 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). Idemudia (2004) explained that cultural differences are often characterized through variation in the expression of symptoms of mental illness. For example, Nigerians who are depressed may complain of heaviness or heat in the head, crawling sensations in the head or leg, burning sensations in the body, and the feeling that their belly is bloated with water (Ebigbo & Iheue, 1982). In contrast, the criteria for the diagnosis of clinical depression in the Western countries are based on individuals’ feelings of worthlessness, inability to start or finish things, loss of interest in usual activities, and thoughts of suicide (Idemudia, 2004). This example illustrates the disparity in how mental health is experienced and presents the need to examine mental illness within a cultural context.

Dien (1997) wrote that the medical system’s misunderstanding of the link between culture and the verbal categories of its language pose a barrier to accessing treatment. He further stated that the word “hallucination” can be taken as a sign of schizophrenia in the West, but is viewed as normal by the native African. Likewise, Reiff, Zakut, and Weingarten (1999) stated
that illness concepts and satisfaction with treatment of African immigrant populations demonstrate the existence of doctor-patient discrepancies in defining illness and expectations for treatment.

One qualitative study looked at the conceptualization of health in Ethiopian refugees to the United Kingdom (UK). This study used semi-structured interviews, documenting analysis, and ethno history as tools of data collection. The participants were found to hold the cultural belief that happiness and good social relations are reflections of good health (Papadopoulos, Lee, Lay, & Gebrehiwot, 2004). Another example of African perceptions of the etiology of mental illness is seen in Uganda. Twenty-nine African traditional healers among the Bagandas of Uganda were interviewed to explore their beliefs about mental illness; all of them reported a belief that it was caused by evil spirits, witchcraft, or curses (Ovuga, Boardman, & Oluka, 1999). Similarly, in a study to evaluate lay beliefs regarding the causes of mental illness in south-west Nigeria, Adewuya and Makanjuola (2008) found Nigerian rural dwellers to be more likely to endorse supernatural factors as causing mental illness, when compared with urban dwelling counterparts.

**Barriers to Seeking Professional Help and Services Utilization**

Newly arrived African immigrants tend to be healthier than native-born Canadians, though this may decline with time (CIC, 2012). This occurs because many immigrants face long waiting periods for healthcare plans and some services are not accessible due to a language barrier. New African immigrants and refugees are less likely than their Canadian-born counterparts to seek out or be referred to mental health services, even when they experience high levels of distress (Chen & Kazanjian, 2005). This can be attributed to both structural and cultural
barriers, including lack of linguistically accessible services, concerns that problems cannot be understood by practitioners because of cultural or language barriers, the fear of stigmatization, and the desire to deal with problems on one’s own (Whitley, Kirmayer, & Grobleau, 2006).

Asanin and Wilson (2008) conducted a study in a Mississauga, Ontario neighbourhood where immigrants represent more than half of the entire population and where 51% of the residents speak unofficial languages. The study explored access to health care and found considerable barriers. The respondents identified three broad categories of barriers that concerned them most: geographical, social, and economic accessibility. Geographically, access refers to the physical location of healthcare services and a person’s ability to receive care at that location, and economically means that in the province of Ontario newcomers do not benefit from any provincial healthcare insurance during their first three months in Canada. Also, one of the impacts of immigration is a loss of social network and family ties. Most immigrants left their family in their home country, including parents and extended family members.

**Stigma.**

The stigma associated with mental illness may be an important factor that reduces help-seeking. Stigma may be defined as a process involving labeling, separation, stereotype awareness, stereotype endorsement, prejudice and discrimination in a context in which social, economic, or political power is exercised to the detriment of members of a social group (Link & Phelan, 2001). Individuals who experience mental illness are often confronted by stigma, fear, discrimination and rejection in the wider community (Link & Phelan, 2001). The stigma of mental illness is another cultural barrier that has an impact on help-seeking behaviour and attitudes among African immigrants. Mishra, Lucksted, Gioia, Barnet, and Baquet (2009)
conducted five focus groups to better understand African American immigrants’ preferences for mental health services and seeking of mental health. This study revealed that stigma serves as a barrier for African American immigrants seeking mental health services and also African Americans associate mental illness with curses, sins, and spirituality rather than health. In another qualitative study conducted in the United States among African women, which also used focus groups as a tool for data collection, depression was found to be a major problem in the community (Seller, Ward, & David, 2006). Participants reported that in the African immigrant community mental health problems are highly stigmatized and they expressed fear that talking about depression could result in increased isolation (Seller et al., 2006).

In one U.S. study of African American services delivery preferences for mental health services and modes of seeking health information, researchers used five focus groups composed of African American men (n=8) and women (n=34) who were unconnected with mental health services (Mishra et al., 2009). The study revealed that stigma served as a barrier for African Americans in seeking mental health information. Mentally ill individuals are kept with their household and hidden away from public view because of psychotic behaviour and are a source of embarrassment to their families. Thus stigmatization of mental illness prevents individuals from acknowledging their difficulties and seeking appropriate help (Sobo, 1993).

Furthermore, stigma is understood as a multidimensional construct that includes both societal perceptions and personal values. To date, people with mental illness are stigmatized in Canada and other Western nations, including United States, Norway, Greece, and Germany. While the level of stigmatization may differ between nations, research suggests that attitudes toward people with mental illness have become increasingly negative over the last decades (Phelan et al., 2000). The public stigma associated with mental illness for mental health services
is viewed as the perception held by a group or society that individuals who seek psychological treatment are undesirable and socially unacceptable, and often leads to negative reactions toward them (Vogel, 2006). As a result, individuals tend to hide psychological concerns and avoid treatment in order to limit harmful consequences associated with public stigma, a phenomenon known as *Label avoidance* (Corrigan, 2004).

**Economic barriers.**

Economic hardship is a significant determinant of health and is linked to health disparities. Economic barriers to integration become significant sources of stress in immigrants’ lives, affecting their families. Some immigrants encounter difficulties in having their credentials recognized, which compromises their ability to find work commensurate with their education level (Noh et al., 2007). Immigrant youth often internalize the frustration of their parents and this in turn affects their own performance in school (Khanlou et al., 2007–2009). On the other hand, some research indicates that even though foreign-born immigrant children are more than twice as likely to live in poor families, they show lower levels of emotional and behavioural problems (Beiser, Hou, Hayman, & Tousignant, 2002). This may, in part, be due to the fact that immigrants expect hardship when they first come to the receiving country and they hope that their situation will improve over time (Beiser et al., 2002). However, if poverty persists this can have negative effects on a child’s IQ and school performance and lead to behavioural problems (Beiser et al., 2002).

**Lack of appropriate services.**

At the larger societal level, culturally sensitive and specific mental health services prove to be the best approaches toward positive mental health outcomes. Despite the best intentions,
services remain underused when formulated without a contextual understanding of the clients they are intended for (Newbold, 2005; Whitley et al., 2006). Services must also account for the fact that immigrants are not a monolithic or homogeneous group and their heterogeneities are significant enough to warrant new delivery models, based on their cultural differences and immigration status. Service agencies and organizations tend to be oriented towards giving information on paper or through the internet, however, a verbal exchange is often the most effective way to provide information about services to newcomers (Khanlou et al., 2007–2009). Research suggests that ethnic media may also be a better way to reach specific populations (Simich et al., 2005), given language barriers.

**Lack of awareness.**

Another major factor that dissuades individuals from seeking mental health treatment is the lack of adequate knowledge about mental illness. As a rule, poor mental health literacy regarding advances in the diagnosis and management of mental illness has been found to prevent people from seeking appropriate mental health care (Hugo et al., 2003). Misinformation about mental illness significantly contributes to the stigmatization of mental health problems and mental disorders in Africa. Within the African community, individuals with mental illnesses are often ridiculed, feared, and rejected by others (Kakuma et al., 2009). Increasing literacy and education regarding the cause of mental illness among Africans has been found to result in desirable improvements in individuals and societal attitudes towards mental illness (Adewuya & Makanjuola, 2008).
Diagnosis and treatment of mental health disorders in Africa.

Although it has been shown that mental illnesses present similarly in Africa and in other parts of the world, their diagnosis and treatment may warrant different approaches than are commonly undertaken in Western society. In their attempt to conceptualize treatment of mental health concerns in Africa, Odejide, Oyewunmi, & Ohaeri (1989) advocated that African mental health care address both the unique and common experiences that all African nations share. For example, they pointed out that a majority of African countries had undergone devastating pre-migration experiences such as colonial experiences, economic turmoil, and socio-cultural problems. These authors, therefore, argue that the treatment of mental health problems among Africans should address these concerns as they apply uniquely to African populations. They further speculate that without the acknowledgement of the aforementioned experiences of Africans residing in Africa and in the Diaspora, it would be difficult to wholly and successfully address arising mental health concerns such as drug or alcohol use, depression, and post-traumatic stress (Odejide et al., 1989). In addition to considering individuals’ pre-migration experiences, the role of traditional healers and medicine, faith and churches, as well as more contemporary Western approaches should be considered in the diagnosis and treatment of mental illness among African immigrants.

Traditional medicine.

Traditional medicine refers to indigenous systems of traditional healing among the peoples of Africa. Research on traditional medicine identifies unique cultural beliefs concerning not only the causes of illness, but also how individuals seek treatment for emotional disturbances and illness. Within indigenous cultures, there is a belief that most diseases are caused by
affliction. Therefore, treatment tends to focus on traditional rather than Western methods. Before colonization, parts of Africa are documented to have had established systems of health care that included the provision of traditional healers who recognized the presence of the mentally ill (Hugo et al., 2003).

Their methods of healing, however, consisted primarily of the utilization of herbs, divinations, and invocations to treat any presenting problems (Odejide et al., 1989). Among the Nyima of Sudan, the ailing individual presented himself or herself to a shaman who discovered the cause and cure of a disease after going into a trance. The shaman did not, however, cure the disease, but referred that patient to other traditional healers for cure (Gadit, 2003). Among some African communities, the belief in traditional medicine and healers has persisted over time. Evidently, the role of traditional healers was, and in some societies continues to be, held in high regard. However, if this deep-rooted belief in the importance of traditional healers within specific African societies goes unrecognized, most Western methods of approaching and dealing with mental health problems may be rendered ineffective. In his study of disease classification in rural Ghana, Fosu (1981) found that most diseases thought to be from supernatural causes were treated with traditional medicine. He went on to point out that each Ghanaian family seemed to have its own herbal recipes for treating what they believed to be supernaturally caused diseases. When these treatments failed, their next choice of treatment often fell on the community traditional healer. Additionally, these Ghanaian communities tended to believe that supernaturally caused diseases would be unaffected or even aggravated by visits to mental health clinics or modern remedies (Fosu, 1981). Community members, therefore, sought out modern medicine only for symptom relief, believing that only the traditional healer could bring about healing for the spiritual concerns. Consequently, although the signs and symptoms of what was
believed to be a supernaturally caused disease may have subsided with the help of modern medicine, the subjective view of the presence of the sickness persisted as long as the spiritual cure had not been addressed. These findings have further implications for mental health professionals and clinicians working with African immigrants.

It is important for the clinician not only to find out the individual’s beliefs concerning the relationship between their symptoms and supernatural causes, but it might also be important for the treating clinician to incorporate individuals’ traditional healing practices in his or her treatment in order to improve the chances of success with treatment.

**Faith and churches.**

In addition to traditional healing practices, another institution that has an impact on mental health treatment in most African societies is that of the church. For example, a review of treatment tends to focus on the traditional rather than the Western methods (Sorsdahl et al., 2009). A review of the literature shows that for Orthodox Christians, holy water is spring water that is regarded as holy-given by one of the saints for healing the sick. Healing is done through baptism of the afflicted individual and drinking the holy water in association with prayer, reading the bible, or using a chant specific to that purpose (Ethiopian orthodox web site, 1999). Sorsdahl et al. (2009) found that 49% of their Black South African study respondents reported consulting with religious and spiritual advisors. Clergy in these churches cultivate beliefs in the supernatural (Odejide et al., 1989). These beliefs are usually not compatible with Western health belief models (which attribute the presence of illness to biological and environmental factors, usually excluding supernatural involvement), making it all the more difficult for most African immigrants suffering from mental health problems to seek help from qualified professionals.
Given the importance placed on traditional and religious healing practices among African societies, Jegede (1981) suggested that the usual order of help-seeking behaviour is that the patient first seeks out the traditional healer and then goes to the church for prayers or healing. If that proves to be ineffective the help of medical professionals, such as doctors and nurses, is finally sought. This might present additional concerns if a similar pattern exists among new African immigrants in this country. However, very little is known about the mental health status of African immigrants in Canada due to the fact that very little research is done among this ethnic group. This gap in knowledge indicates a need for this thesis proposal so as to understand African immigrants’ experience of help-seeking behaviour for their emotional and psychological issues.

**Purpose of the Study**

The purpose of this study was to describe and explore the experience of African immigrants in seeking help for their mental, emotional, and behavioural problems. This is of interest as relatively little research has been conducted regarding health and illness among this group of immigrants (Wen et al., 1996). African immigrants are a minority population that may not have the voice to advocate successfully for their mental health needs. This could be due to the fact that they may be unaware of the presence of mental illness symptoms, may not readily acknowledge the severity of their psychological concerns, and might not interpret their negative psychological experiences as mental health symptoms. They may, therefore, be less likely to seek out mental health services that may be available within their respective areas. In turn, healthcare workers might be unaware of the needs of new African immigrants and would, subsequently, be less likely to intervene when necessary. Findings from this study will, therefore, assist the service providers to identify barriers that prevent help-seeking, and to provide
culturally competent care and interventions to African immigrants. Findings illustrate barriers to mental health care that can be used to guide interventions as well as future research with similar groups.
Chapter 3: Method

The purpose of this study was to describe and explore the experience of African immigrants in seeking help for their mental, emotional, and psychological issues. This chapter presents an overview of the research design and analysis, data collection, and data analysis.

Research Design and Analysis

In this chapter I will explain my choice of method as a way to answer my research question. To understand the world of these immigrants’ perceptions of help-seeking for their emotional and psychological problems, one would need to have the privilege of listening to their experiences. When interviewing these immigrants one must pay close attention to their stories, listen without judgment, and encourage the flow of their conversation, then afterwards attempt to locate and reveal the meanings of these stories. Content analysis was selected as the appropriate analysis method based on the recognition of the importance of obtaining a rich description of the narrative.

Content analysis is a research approach and scientific tool used in order to provide new insights, improve research understanding of particular phenomena, or inform practical strategies (Krippendorff, 2004). Content analysis as a research method is a systematic and objective means of describing and quantifying phenomena (Downe-Wamboldt, 1992; Krippendorff, 1980; Sandelowski. 1995). It was first used as a method for analysis of hymns, newspapers and magazines and other documents containing written, verbal or visual communication messages (Cole, 1988). In nursing, it is mostly used in psychiatry, gerontological, and public health studies. Content analysis involves a process designed to condense raw data into categories or
themes. This process uses inductive reasoning, by which themes and categories emerge from data through the researcher's careful examination and constant comparison.

The benefit of implementing content analysis with the collected data is that it offers a greater comprehension of the phenomena (Kreuger & Neuman, 2006). It can also be advantageous in terms of money and time (Royse, 1999). Related to this is that content analysis can be performed without a lot of specialized training and can be redone without having to obtain any new data (Royse, 1999). However, reliability becomes a major concern since two researchers may come up with different themes even when analyzing the same data.

Content analysis is a very valuable alternative to more traditional quantitative content analysis, when the researcher is working in an interpretive paradigm. The goal is to identify important themes or categories within a body of content, and to provide a rich description of the social reality created by those themes or categories as they are lived out in a particular setting (Schreier, 2012). Through careful data preparation, coding, and interpretation, the results of content analysis can support the development of new theories and models, validate existing theories, and provide thick descriptions.

**Respondent numbers.**

Procter and Allan (2007) suggested a common range in qualitative research is usually between eight and fifteen participants, but this can vary. The small size is suitable because of the potentially detailed data that can be generated from each participant. The population of interest is new African immigrants who are currently residing in Ontario. I chose a sample size of eight people who met the inclusion criteria. The establishment of inclusion and exclusion criteria increased the precision of the study and strength of evidence (Haber, 2006). There were five men
and three women, and their ages ranged between mid-twenties and late-fifties. The sample size in qualitative research depends on when theoretical saturation and qualitative information in the collected data is considered to be achieved (Sandelowski, 1995). In this study the sample size was considered adequate when the same pattern began to repeat itself in the interviews. After listening to the tape-recorder, transcribing, reading and rereading the transcripts and then contacting the participants by phone to ask for clarification of unclear points from the interviews, and when we both had the feeling that there was no more to say or ask, I concluded that saturation in the data collection was achieved.

**Recruitment of respondents.**

The subjects for the present study consisted of eight African immigrants from East Africa (Kenya, Rwanda, and Tanzania), West Africa (Senegal, Ghana) and Central Africa (Cameroon) residing in Ottawa, Canada for periods of between one and five years. Recruitment posters were posted throughout settlement and immigration centre (Appendix A). Additionally, study information was forwarded to friends and acquaintances. Word-of-mouth from respondent to respondent, known as “snowball sampling”, was a strategy used to recruit respondents for this study (Patton, 2002, p. 237). The idea of this strategy is that as the “snowball” increases, key contacts suggest additional key individuals to the researcher. Individuals were selected who met the following criteria:

- Self-identified as African immigrants;
- In Canada for up to five years and currently resided in Ottawa, Ontario;
- Had a basic command of the English language;
- 18 years old or older; and
• Had never been diagnosed or treated for serious or persistent mental illness, and not currently taking psychotropic medication.

Ottawa and the surrounding environs were selected for data collection, primarily for feasibility. The rationale for focusing on recent immigrants was to recognize the initial challenges immigrants experience while relocating to a new culture and society.

Data Collection

Location of interview.

Respondents were recruited from the larger community through posting flyers in settlement centres and immigrant centres in Ottawa, Ontario. The flyers had the name and contact information of the investigator so that the respondents could contact the investigator directly (Appendix A). The interview locations were determined by the respondents. Five interviews were primarily at respondents’ residences, two respondents met with me at the building where the local African immigrants held their monthly meeting, and one interview took place at the respondent’s job site.

I was the sole collector of data, and conducted the interviews in a safe, and preferred area that was accommodating for individuals. Eight respondents were interviewed and the length of the interviews ranged from 30 minutes to 70 minutes. I used interview strategies, such as remaining attentive, providing non-verbal cues, such as nods, moving closer to the respondent, and maintaining eye contact to communicate interest and encourage the flow of communication (Sorrell & Redmond, 1995). Davies (2007) asserts that the researcher must be able to engage with the interviewee in a setting that is relaxed and familiar to them, free from distraction, and
conducive to conversation to allow participants to talk freely about possibly emotional and confidential matters.

Prior to beginning the taped interview process I gave each respondent a thorough explanation of my interest in conducting the study and the purpose of the study. Once potential respondents felt satisfied with the information obtained, each respondent signed an informed consent form (Appendix B). Each respondent then completed the personal Data Information form or Demographic Sheet (Appendix C). Codes were assigned to each respondent to ensure the maintenance of confidentiality.

**Organization of the data.**

Once the interviews were completed, the tapes were played and replayed and meditated upon, and then transcribed verbatim. I chose to transcribe immediately, while the tape-recorded interview was fresh in my memory. Immediately after the interview sessions, I left the interview area and in the privacy of my parked car generated analytic notes and personal thoughts. I also made notes in diary form about the respondents, including tone of voice, body language, laughing, crying, as well as my own response to their stories and words. This was added as part of the decision trail for this study.

**Data Analysis**

**Unit of analysis.**

Content analysis usually uses individual themes as unit of analysis. Themes might be expressed in a single word, a phrase, a sentence, or a paragraph. When using themes as coding units, you are primarily looking for expression of an idea (Krippendorff, 1984) The coded data is
then categorized and labeled according to broad conceptual categories. The categories represent a collection of content that shares a commonality (Krippendorff, 2004). This categorization is useful in summarizing meaningful prospects that will provide preliminary answers to the question posed. Common themes are then identified and described within the context of the literature. Once the themes that are representative of the data as a whole emerges, the researcher develops thematic descriptions to capture each emerging theme. The researcher returns to the data and identifies direct quotes and passages that represent and exemplify each of the themes. Finally, the researcher synthesizes the themes into a composite description of the lived experience reported by the respondents in the study.

**Preparing the data.**

In content analysis, data results from the procedures the researcher has chosen to use to answer specific questions concerning the phenomena in the context of the given text (Krippendorff, 2004). In this study, data resulted from narratives recorded from in-depth interviews with respondents.

Initially, the researcher transcribed the tape of the conversation and then transcriptions were checked and rechecked against the tape, in order to make sure that the transcript accurately recorded the conversation. Through the process of transcribing the tapes of conversations, the experiences described were transferred to written text. The content analysis was then conducted on the written version of the responses.
Open coding.

During the first step, open coding allowed the researcher to look for processes and begin identification of major categories and subcategories as well as to describe the major properties and dimensions. The transcripts were analyzed word-by-word and line-by-line, and by assigning labels or names (Krippendorff, 2004). The words of the respondents were used as substantive codes. The codes appeared as respondents described their help-seeking behaviour. Using a table format, the codes were sorted inductively from the data into emerging main categories and subcategories based on the relationship between different codes. I began with numerous codes and then reduced them so that each of them represented a concept. The list of codes was reviewed and developed into themes in collaboration with the thesis supervisor, Dr. Kevin Woo, and committee member, Dr. Rosemary Wilson.

Ethical issues.

Prior to data collection, the study procedure was reviewed and approved by the Queen’s Ethics Review Board at Queen’s University. All participants were provided with information sheets detailing the aims of the research process. Respondents read the consent form and the researcher asked subjects if they had questions. After signing the signature page, participants were given a copy of the information. Respondents were assured their confidentiality would be maintained through the use of pseudonyms in the research reporting and by changing specific contextual details that could reveal the identity of the respondents. Burns (1989) claims that failing to obtain consent from respondents and failing to inform respondents of their rights, including the right to withdraw from the study, is a threat to ethical rigour. In addition, the respondents were told of the benefits of their participation. From this information, mental health
services providers will have the opportunity to improve the quality of services and increase mental health services utilization for African immigrants. In the interview, the respondent needs to feel that he or she can trust the interviewer to respect the promise of confidentiality. That trust was built throughout the interviews and each respondent was reminded of her or his right to withdraw from the study. I assured them their dignity and privacy would not at any time be abused. The respondents were, furthermore, told how interview material would be kept secure and that they would be granted pseudonyms in the presentation of the study.

**Robustness.**

Rigour refers to the extent to which the researcher strives for excellence and adheres to detail and accuracy. Parahoo (2006) highlights that although rigour can be difficult to determine in qualitative research, researchers want their findings to reflect truthfully the phenomenon they are studying and to contribute to knowledge that is beneficial to others. The researcher proposed to use a framework by Lincoln and Guba (1985) to increase the trustworthiness of this study. This framework encompasses the following four criteria for developing trustworthiness of this study: credibility, dependability, conformability, and transferability.

**Credibility.**

Lincoln and Guba (1985) state that research is credible when it presents faithful descriptions and when readers confronted with the experience find it recognizable. Should differences be observed, then the researcher must show how each theme was derived from the description, and this is done by returning to the text to make sure all the conclusions are grounded firmly in the data or explained by the researcher’s interpretive scheme (Koch, 1995). The credibility of the data analysis was confirmed by member check and peer check techniques.
In member checking, I returned the summary of the interview to the respondents, and they confirmed that I was representing their ideas. For peer checking, I did coding and categorizing independently and shared this with my thesis supervisor and committee members during regular meetings. Where there was disagreement, discussion and clarification continued regarding the coding frame and main analysis until we reached consensus.

**Dependability.**

Dependability is concerned with the ability of the data to remain stable over time, determining whether the study findings would be replicated if undertaken with similar participants in a similar context. Credibility cannot be attained in the absence of dependability. I used an audit trail to enhance the dependability of the study. This involves tracking and recording all decisions which have influenced the study so an outside individual can examine the data (Dempsey & Dempsey, 2000). In my study this was accomplished by documenting all steps and decisions in the research process, such as collection of data and data analysis. I kept a record of all decisions regarding the study with all other information in a locked place.

**Conformability.**

Conformability refers to the data representing the information participants provided. There should be no biases or subjectivity in the study; the findings must represent the respondents’ voices (Polit & Beck, 2010). The researcher upholds this principle by clarifying all information with the respondents. Member checking was used at various stages of data collection and data analysis. During the initial interview stage I discussed interview questions with respondents during formal interviews. I then fed ideas back to respondents to refine, rephrase,
and interpret. During informal post-interview sessions I gave each participant a chance to discuss the findings.

**Transferability.**

Transferability involves the extent to which the findings of a qualitative study can be useful to similar groups or situations (Parahoo, 2006). The transferability of the present study was ensured by rich description and reporting of the research design, sampling, recruitment, data collection, and data analysis as outlined in this chapter of the research study. Future researchers can judge transferability based on the detailed description of the study.
Chapter 4: Presentation of Findings

The threefold purpose of this study was to explore the lived experience of new African immigrants as these experiences pertained to their help-seeking behaviours for their mental, emotional, and behavioural health problems.

Demographic characteristics.

Demographic data were collected prior to the interview process to provide a description of the study participants and determine if participants met inclusion criteria. In order to maintain confidentiality and anonymity, each participant was assigned a code by the investigator. The age, duration of residence in Canada, marital status, highest level of education obtained, and family income of participants are presented in Table 1. Regarding marital status, none of the participants were currently separated, widowed, or “other” (which could include common law relationships).

In regards to household composition, almost all participants lived with someone, usually with their children and spouse or significant others. Almost all participants were independent immigrants.

Theme Identification

Emerging from the data analysis, the findings from this research consist of concepts, themes, and subcategories. The overarching concepts were: respondents’ views on mental health, mental health resources, and coping strategies. The identified themes were as follows: 1) Respondents’ thoughts on causes of mental illness; 2) Mental illness appraised as a threat; 3) Social/Environmental resources; 4) Personal resources; 5) Cultural appraisal; 6) Response to self; 7) Taking care of my emotional social/spiritual self; 8) Taking care of the physical body.
Table 1 *Demographic Characteristics of Participants (N=8)*.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Female (N=3)</th>
<th>Male (N=5)</th>
<th>Total (N=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of Participants (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 40 years</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>More than 40 years</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Duration of Residence in Canada (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>3-4</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Marital Status</td>
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<td></td>
</tr>
<tr>
<td>Never married</td>
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<td></td>
<td>2</td>
</tr>
<tr>
<td>Married</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Divorced</td>
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<td>1</td>
</tr>
<tr>
<td>Highest Level of Education</td>
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<td></td>
</tr>
<tr>
<td>Bachelors</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Some college</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>High school</td>
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<td></td>
<td>4</td>
</tr>
<tr>
<td>Family Household Income ($CDN)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10,000 or less</td>
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</tr>
<tr>
<td>11,000-30,000</td>
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<td></td>
<td>6</td>
</tr>
<tr>
<td>31,000-50,000</td>
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<td></td>
<td>1</td>
</tr>
</tbody>
</table>

The concepts (identified in shaded boxes) and themes (identified in italics) are illustrated in Figure 1.
Respondents’ Views on Mental Health

One of the overarching concepts that emerged as an issue was to clearly understand “what is mental health”. Mental health had various meanings for the respondents. When asked, what does the term “mental health” mean to you, the themes that emerged were mental health appraised as a threat with the following subcategories: fear, crazy, right mind. Causes of mental
illness had the following subcategories: supernatural causes, stress-related, and negative thoughts.

**Mental illness appraised as a threat.**

The way an individual appraises a situation may be very important to his or her psychological well-being. Fear and apprehension about mental illness and/or the negative social consequences of seeking care can play a role in the decision to change unwanted behaviour or to engage in healthy behaviours. Mental illness had various meanings for the participants, including fear, crazy, mad, weird to discuss, overload of a lot of things, psychiatric, depression and schizophrenia. The sufferer is always regarded as responsible for the manifestation of the illness, although not necessarily in a conscious manner.

**i) To be feared.**

When asked about their perceptions surrounding mental illness, the majority of participants associated mental health with fear, something they are afraid of and something that is not openly discussed. Mental illness is still feared and misunderstood by many people. The findings of this study reveal a general reluctance to seek help for fear being judged or misunderstood by the general public. The majority of the respondents fear disclosing any symptoms, as it might be associated with mental illness and stigmatized.

**Osman:** I think when I hear mental health I think of someone mad, crazy, someone I could be afraid of.... it could be someone the family or friend may be afraid of.... you definitely do not go around talking about this person, at least freely...
Grace: I feel kind of weird to discuss mental health.... because I have never actually thought about mental health. It is not something I can really think about it on daily basis, it’s a bit scary for me yeah....

ii) Crazy.

In regards to mental health, the participants were asked what the term “mental health” meant to them. The overarching responses to this question were negative. Most of the participants used words and phrases like crazy and mad.

Mrs Watson: I think of someone mad, crazy, someone I could be afraid of.

According to most respondents, mental health is a topic that is not openly discussed or used in any serious conversation as it has stigma attached to it.

iii) Right mind.

Some of the respondents defined mental health as having “right mind”. According to Patrick, for someone to be considered mentally sound, there should be nothing bothering them.

Patrick: Mental health for me it means the state of being in right mind and consciousness without any internal and external disturbance temporally or permanently.

Additional themes that emerged as participants shared their perceptions of mental health were the labels ascribed to it in psychiatry, as related by Peter.

Peter: Mental health means psychological health that, damage to the brain or related to psychology of individual due to over thinking.... Personally I really think of psychiatric,
depression... and schi-zo-phre-nia.... *(stammering on the word)* those diagnosis that you hear about every now and then on television shows, in commercials and magazines.

**Respondents’ thoughts on causes of mental illness.**

Causes of mental illness were categorized into four types: supernatural; negative thoughts; stress related; and family role strain. When asked about their perception of mental health over years, two subcategories emerged: in Canada mental health is normalized; in the country of origin there is discrimination and negative perceptions around mental health.

**i) Supernatural causes.**

Respondents in this study expressed the belief that genetics is a dominant etiology or precursor of mental illness. Some of the respondents stated that mental illness sometimes runs in families, suggesting that people who have a family member with mental illness may be somewhat more likely to develop it themselves. Others believe it is due to bad, evil eyes.

**Grace:** I also believe sometimes to do to bad eye... or wrongdoing somebody and they curse you so you end up with mental problem. Umm.. I also know it sometimes runs in the family back home I know of a family whereby a mother and three children are mentally sick.

**ii) Negative thoughts.**

When respondents were asked about the causes of mental illness, in addition to supernatural causes, some of the following reasons emerged: a person’s reaction to the situation at hand; negative thoughts; weak mind; over thinking; and being a negative person.
Mrs Watson: I think mental health is caused by many problems, bad thoughts, or bad thinking... also some people have weak mind whereby when your experience problem you just can’t hold it so break down.

One of the respondents in his early thirties associated mental illness with bad thinking.

Patrick: I mean you are kind of negative person you dwell so much on negativity.... so your brain give in maybe I could say living alone from family can also contribute to over thinking.

iii) Stress related.

They also associated mental illness with stress. They believe that the stress of thinking and dealing with situations can cause a person to snap, especially if it pertains to employment.

Patrick and Osman responded:

Patrick: Honestly I think it’s due to stress your brain is subjected to...... hence some people can’t handle it so they end up with mental problem, and also bad thinking.... I mean you are kind of negative person you dwell so much on negativity...... so you brain give in. maybe I could say living alone away from family can also contribute to due to over thinking....... and no close support to help.

One respondent was very adamant that negative childhood experiences and environment were significant contributors to mental illness.

Osman: I think the main cause is stress.... because stress is the main thing, which is causing us mental illness. I am thinking it could have started from childhood and also what the child takes in, in their surroundings, the environment, and maybe they don’t know anything
outside that environment also low self-esteem and the need to have someone to actually help them emotionally.

**iv) Family role strain.**

The many roles and responsibilities of immigrant families in the home and workplace can impede their access to mental health services. When asked about whether they ever felt overwhelmed when dealing with psychological stress one respondent answered:

**Grace:** It was hard for us to maintain our home and everything, our little one used to cry at night and my husband was tired.... during the day he was the one who did everything, that time it was very hard. I never used to sleep well at night, headache during the day... I used to just cry.

**v) In Canada mental health is normalised.**

When asked about their perception about mental illness over the years the majority of participants stated that in Canada people with mental illness are more accepted and are well taken care of as compared to in their home country. The respondents stated that they see them attending school and working, unlike in their country where they are treated like they have no place in society.

**Osman:** I was surprised the way people with mental problem are treated here, like it’s not a big deal, I mean no much stigma attached to it.... because in my country you can’t just talk about, people hide it don’t like to be known they have mental problem because of the way society view you like are you done........., no place in society... but here I see good services been mental illness because given to people with disability.
vi) Country of origin discrimination and negative perception.

When respondents were asked about their perceptions regarding mental health over time most of them stated that there is a lot of discrimination against and negative perceptions of people with mental health in their country compared to Canada.

**Patrick:** Yes since I come to Canada so many things changed in mind because back home if someone have mental issues or disabilities you are not treated well... I can say so many discrimination.... but when I come here I saw people who have disabilities working and attending university, their rights being taken care of, so I think, I am trying to realize that mental illness is not you know a permanent thing so it can...... it’s just anything that can happen to anyone and people who have mental health issues can do many thing that many people can do so certainly I see some as compared to my country.

**Osman:** I was surprised the way people with mental problem are treated here, like it’s not a big deal, I mean no much stigma attached to it.... because in my country you can’t just talk about, people hide it don’t like to be known they have mental problem because of the way society view you like are you done........., no place in society... but here I see good services been mental illness because given to people with disability.

Mental Health Resources

**Social/Environmental resources.**

Despite the fact that all health services offered in Canada are available to landed immigrants, their use of mental health services consistently lags behind that of the general population. When respondents were asked about the mental health resources they were able to
use to relieve their psychological stress, social and environmental resources emerged as one of the major themes within all other themes. This was further divided into two subcategories, lack of knowledge about resources and lack of trust.

**i) Lack of knowledge about resources.**

In deciding whether to take action about their mental health concerns, the majority of respondents stated they didn’t know where to go for resources, while others thought there was no need for such services. They also thought health professionals would not understand them.

**Mrs Watson:** No I didn’t sought any help, yeah, umm... I don’t know if there is such resource available, nobody told me, it’s kind of hard. I try to fix it myself and get pass it.

**ii) Lack of trust.**

All respondents said that they had never attempted to seek any kind of treatment for mental health problems. They reported that they did not trust the healthcare providers. They were concerned about the stigma associated with mental illness. Some immigrants downplayed the severity of their own situation and expressed feelings of guilt and mistrust about revealing their personal and intimate information to someone they do not know. Almost all respondents feared sharing their problems with others for fear of being misjudged.

**Grace:** for me to be honest with you, as Africans we don’t like to go see psychologist, we think if we go there they will give us medication and we become very sick, (umm, chuckles) sorry to say that and then if we have problem we use to call someone talk about it and its finished hence you don’t need to go see a doctor or psychologist. *(long pause)* I feel that doctors don’t understand I don’t need to waste my time with them.
Resettlement and its challenges.

Being unprepared to settle in a foreign country that is very different from one's home country brings its own challenges. These resettlement challenges were further subdivided into four subcategories: why am I here; Canada, land of opportunity; loneliness; and language barriers.

i) Why am I here.

In the interviews with the respondents about their experiences of seeking help, they questioned why they had come to Canada and what had brought them here. The perception they had about Canada was quite different than the reality on the ground. Results of in-depth interviews with some respondents revealed that when most immigrants enter Canada, they are unaware of what will come next. They do not know whether they will be able to find employment. Most of the participants reported having difficulty finding employment that matched their skills and education.

Mrs Watson: Sometimes I regret of coming to this country, because I had good job back home, coming here to do lower job is very hard for my self esteem.... My friends back home ask me what I am doing I am so embarrassed to tell them I work at Tim Horton, when back home I use to have office with secretary..... When I think of it emotionally drains me.

Patrick: I left very nice job back home, life was very comfortable at home, then when I come here things take different turn..... I can no longer work as per my previous job, My credential they say not as per Canadian...., I totally lost direction, I felt very low.... and just to go
back home, but you know on other hand what will tell my family who expect so much from me.... I kind of got caught in between, I almost lost my mind...

**ii) Canada, land of opportunity.**

Most of the respondents reported that the perception they had of Canada was that it was a land of opportunity but that the reality on the ground is different. Respondents thought that Canada was a place that presented many possibilities for people to earn a prosperous living, and succeed in their economic or social objectives but the reality is different when they land in Canada. New immigrants were consistently shocked at how difficult it is to break into the job market. For example, some respondents encountered difficulties in having their credentials recognized, which compromises their ability to find work commensurate with their education.

**Osman:** Also regarding work related problem. I come here they told me my credentials are not equivalent to Canadian standard, you see I have children to feed and bills to pay cant because they say no Canadian experience..... so I use to have sleepless night just thinking on what to do, I ended up doing odd job just to survive...... it’s very trying moment in my life..... (as he says that his facial expression changes, nose are flaring and I could fine sweat on his forehead). I kind get bad headache and my whole became weak, so I don’t really find it necessary to see I a doctor..... because you they don’t understand.

**iii) Loneliness.**

Almost all participants faced issues of loneliness and alienation at one point in their lives. When asked about the challenges they face as new immigrants almost all participants spoke of being lonely, having no one to talk to when they have problems, being away from home.
Mrs Watson: I think staying alone is an issue..., back at home we have friends and families but here Ottawa you are alone. Probe, how is it challenging to you? to feeling alone.... I don’t have close friends and family to share my feeling with, if I come overwhelmed by emotions due so many thing going in my life

iv) Language barriers.

Language issues were also identified as one of the barriers to utilization of mental healthcare services. When making first contact, some of the respondents feared that their service providers might misunderstand them, either because the respondent lacked the ability to express medical terms in English or because English language choices did not always convey the intended meaning. Lack of linguistically accessible services, a desire to deal with problems on one's own, the concern that the problem would not be understood by practitioners because of cultural or linguistic differences, and fear of stigmatization are some of the hindrances that held back new immigrants from seeking help.

Patrick: Also language was also a big issue for..... kind off I don’t understand how they talk so most of the time I just kept quiet so it really stresses me. Yaa again you culture is also a big thing......, you know yaa I mean culture shock staff like that.

Cultural appraisal.

Cultural expectations and roles are considered important topics in immigrant communities because they have a vast impact on the immigrant’s self-perception and acceptance within the host community. For African immigrants, cultural barriers have a significant impact
on their help-seeking behaviour in accessing mental health services. Cultural appraisal was divided into three different categories: stigma; taboo; and gender expectation of strength.

\textit{i) Stigma.}

Stigma about mental health is a significant problem for African immigrants. In this study it was viewed as a cause of both social distance between those with mental illness and those without, and lack of support for family members who have relatives with mental issues. It is commonly believed that the fear of stigma may deter persons with symptoms of mental illness from acknowledging that something is wrong, seeking help, and continuing with any recommended treatment. This is what some of the respondents have to say.

\textbf{Mrs Watson:} Yah, in some sense I see that people here are more open about it, then hiding it but what I am not sure is how they are perceived by the society they live in... because back home the family member hide their loved once for fear been ridiculed..... so I mean it is hard to say I have mental problem or issues as I am afraid been branded mad... crazy all kind of things.

\textit{ii) Taboo.}

According to all respondents, mental health was not a topic to be openly discussed or referred to in any serious conversation. It is considered to be shameful to have mental issues, and people prefer to discuss it in secret to avoid stigma. This sentiment was reflected in many statements made by respondents and in the researcher’s observations.
Patrick: Also I don’t like to tell I have mental stress because they might think I have gone mad or crazy.... something like that because back in my country mental issues are not discussed openly like I mean open like that....

iii) Gender expectation of strength.

Some of the respondents who reported they will not share their mental/emotional stressors with anyone made this decision based on the stigma of having a weak mind and the labeling that would ensue. They also characterized help-seeking as a sign of personal weakness and some individuals only sought help as a matter of last resort.

James: I think people should let out their feeling so their mind wont snap, but in my culture it’s a shame and stigma if you let your feeling of emotional problems out..... you are regarding as weak man, ......You know in our culture men are regarded as strong not to cry in front of people so all these factors held you back umm yaa.....

Positive Coping Strategies

How individuals appraise events can influence their coping strategies. Individuals vary greatly in their perception of stressors, and some people cope in ways that increase positive outcomes more than others. The concept of positive coping strategies has two major themes, emotion-focused coping and problem-focused coping.

Emotion-focused coping has a sub theme of taking care of emotional/social self with the following categories: emotional symptomatology; use of family and friends; positive self talk; preventing family worries; and self isolation. Problem-focused strategies has a sub theme of
taking care of physical body with the following categories: diversion/distraction; use of spirituality; and counseling services.

**Emotion-focused coping.**

**Taking care of emotional/social self.**

To expedite the relief of mental/emotional stressors that manifest through moods or physical discomfort, respondents engage in various activities. Besides taking over the counter medications for physical discomfort, respondents reported keeping things in perspective, praying, and involvement in diversions/distractions. Regarding questions that addressed the overwhelming experience felt when dealing with psychological issues, respondents were able to identify mental/emotional stressors either via their mood or by physical signs.

*i) Emotional symptomatology.*

The respondent who identified mood as a sign of their particular emotional stress discussed getting headaches, crying, my heart beats/pump too much, chest and body feel tense, my mind just snaps, can’t sleep well at night.

**Patrick:** When I have mental stressor, I know because I just can’t focus...., become very low, isolate myself from friends and family..............., become angry and just shout at slight provocation, then lock myself in my room and sometime I kind of pace up and down in my room, then I think of what brought me here, life can sometime. Life be so cruel you know.

**Osman:** When I have mental health stressor, sometimes my heart will just feel like it’s working too much..... and it’s like saying okay, like my mind will just snap, so I slow down and then a headache come on and my body become tense.
In addition to changes in mood as a sign of mental or emotional stress, respondents also reported physical signs. The physical signs of an emotional stressor, as expressed by respondents, ranged from decreased sleep, to no sleep, to headache.

**Peter:** Imagine it was winter and I come from Africa.. so it was total difference, so I ended up talking to myself... it wasn’t easy for me cope up, I was not able to cope my family members, I didn’t even know where to buy calling card I was so overwhelmed with stress. There is a day I was so overwhelmed that I started hitting my hands on the wall, I didn’t feel any pain but I started to cry a lot.... prayed and meditated a lot about what brought me here.

**ii) Use of family and friends.**

The majority of the respondents use informal coping mechanisms, such as talking to family and friends. Respondents in this study come from cultural backgrounds wherein family members are usually consulted about any health problem. Migration can stress and fragment families, close family members might be left behind, and this can hinder the coping strategies available to these immigrants.

**Mrs Watson:** I call my family, we talk about my feelings, issues like that... when was the need to seek help identified and I like to go church and I got so many friends from church, then they become part of my family, we shared everything I have...... my emotions and then I feel comfortable.

**Emanuel:** making friends in the residence where I use to live, that helped me a lot, telling us opportunities available in this country and you just say, even I have problem in this country,
have to struggle and get that opportunity may be, get a good job and help my people back home all those things, that counseling encouraged me and help me a lot.

iii) Positive self talk.

Some of the respondents stated they use other means of addressing mental health/emotional stressors. Some of the strategies they use to handle emotional issues are: facing the situation; trying to downplay it; putting things into perspective; and trying to stay strong.

Mrs Watson: I keep myself mentally healthy...... by not allowing things to get me down, I try not to let anything bother me too much, I try to stay strong mentally.

Elizabeth: When I am faced with problem I kind of face it..... and try to down play it, may it will help as escape route as I cannot correct things the way they are, just stay positive think good old days growing up in Zambia My parents died when I was 10 years.... I was brought up by my grandparents, so I learnt from my grandmother that prayer makes your mind strong.. she was strong willed person, she told as us in case of any problem stay tough but not crumble at the slightest misfortune, so you see I learnt from her to survive however hard the situation is.

iv) Preventing family worries.

Some of the respondents expressed the need not to share their worries with family members in order not to cause them to worry. Some thought they might not be believed and some thought they might be blamed.

Osman: I am kind of private person, I don’t like sharing my problems with strangers.... (He sits back, looks thoughtful, his eyes mist over) just kept it cool, sometime I am torn between
not tell my family back home because they think it good here, or not make them worry about me so much.

**James:** I kind of avoid to tell my wife I am stressed..... cause she will start think too much and blame me, so I kind avoid sharing my problem with anybody because I know they might not take it lightly.

**v) Self isolation.**

On the flip side of the coin the majority of the respondents admitted not wanting to talk to a friend or family member if they had a mental health/emotional stressor. The reason most of them gave is that family sometimes judges you the wrong way, stigmatizes you, or labels you as crazy or mad if you share how you are feeling.

**Mrs Watson:** Sometimes I don’t wanna accept that these might be a problem... because then they’ll take it as something wrong with me, I kind of kept it within myself.

**Peter:** Sometimes you have to be careful when you talk to your family because you can be called mad man..... a mad man of some sort... but sometimes not that at all, just a little unrest and a person may need to talk and take a little break from work or school to get some rest, umm... ya
Problem-focused coping

Taking care of physical body and self.

The theme that emerged in regards to problem focused coping strategies is taking care of physical body/self with diversion/distraction, spirituality, and counseling emerging as subcategories.

i) Diversion/distraction.

Diversion/distraction was one of the predominant sub-themes that emerged as respondents explained how stressful situations were handled. The most prevalent activity and brain occupation mentioned as a means of dealing with mental health/emotional stressors was the act of reading.

Patrick: I also like reading books especially novels... to keep off my mind from thinking.... so much. but overall I just kind of find an outlet or some activity to keep my brain running well and avoid distracter.

Osman: Sometime when I feel stressed..... I go to my room and just lock myself away and read book especially spiritual books I read to get stuff out of my mind. A lot of times this work but most of the time it doesn’t, so I pray so much.

Other diversions/distractions discussed as a means of dealing with mental health/emotional stressors pertained to participation in physical activities. These activities included listening to native music, exercising at home or at the gym, taking a walk, doing crossword puzzles and travelling.
James: When I have an emotional situation brewing....... I need something to relax my mind like I mean listening to music from back home and jogging around the house may sometime helps.

Mrs Watson: I try not to get stressed out with things, I keep myself active by taking trip out of town or by doing crossword puzzles and so on. I keep myself mentally healthy......

ii) Use of spirituality.

In African culture, religion plays a major role and governs all aspects of life. Most of the respondents reported that they are more confident in praying versus talking to anyone.

Osman: Sometime when I feel stressed..... I go to my room and just lock myself away and read book especially spiritual books I read to get stuff out of my mind. A lot of times this work but most of the time it doesn’t, so I pray so much.

Emanuel: Ok like to me what I value is if I have problem... like as my background I am a Muslim, whenever I have problem I have to go back to religious teaching like I read Quran, I pray a lot so ask God to help to cope with situation.... mainly what I do is when I have problem is to read Quran and pray.... so that to get relief all that I have in my head.

iii) Counseling services.

When asked about how they seek help for emotional stress or issues, only 2 out of 8 respondents said they used the services of a counselor.

Emanuel: Some of help I get is I use to get counseling and encouragement that helped me to progress well as time goes..... like I used new comer programme.... that help people to
integrating in to the community and the life in the city, so like those people they use to come to me ask question, take out for dinner and talk to people, making so interacting those people made....

**Peter:** Umm... ya, the counselor was very helpful, though I only went for one session and I could it was kind of brief, may be it could have been longer I think....

**Summary of Findings**

The aim of the current study was to examine the help-seeking behaviour of African immigrants for their emotional and psychological stress during their first few years in Canada. Immigrants in this study face a myriad of stressors that can affect post immigration mental health and access to care (e.g., limited fluency in the host country language, unfamiliarity with available services, beliefs about illness and treatment that diverge from those of the host culture, cultural appraisal, to name a few). The findings from the present study underscore the importance of the different dimensions of culture, mental health and help-seeking. For example, this study found that happiness in the family and family-centric orientation figured prominently in the lives of the respondents while growing up in their home countries. Hence, there was extreme distress when there were losses in the family and in their social network. This shows how notions of mental health, help-seeking and psychological distress are influenced by cultural factors that are deeply embedded in the group history, upbringing, and life experience of a person.
Chapter 5

Discussion of Significant Findings

This study explores mental health help-seeking behaviours among new African immigrants. Demographically, the respondents are between 30–50 years of age. More male than female respondents participated in this study. Most of the respondents are married, however, most reported that they resided with a significant other. The majority of the respondents had received an education beyond high school and slightly more than half earned income of at least $25,000 or more per year. Almost all of the respondents in the study denied receiving mental health services. However, it is possible that the stigma associated with mental illness may be an important factor that reduces help-seeking.

There was a scarcity of literature on African immigrants and their mental health status. However, to give insight and relevance to the findings of the present study, the researcher has compared the findings to existing literature related to immigrants’ mental health and health help-seeking behaviour. The comparisons also helped to distinguish similarities and differences between this study’s findings and those found in existing literature.

Concept of Mental Health/Illness

Most of the participants had difficulty in defining the term mental health and the focus was centered on mental disorder. Although mental health and mental illness have different definitions, participants considered mental health as a synonym for psychiatric illness. These findings are similar to the findings of Momenzadeh and Posner (2003) in their study of Iranian immigrants. The findings of this study show that mental illness had various meanings for the
participants, including being cursed, crazy, mad, evil spirit, genetics. Within the African community, individuals with mental illnesses are often ridiculed, feared, and rejected by others (Kakuma et al., 2009). As noted in Odejide, Oyewunmi, and Ohaeri (1989), attribution beliefs in supernatural causes of mental health concerns tended to remain unchanged despite educational status. Furthermore, many African societies believe supernatural forces cause mental illness and this affects the choice of mental health healers. An example of African perceptions of the etiology of mental illness is seen in Uganda. Twenty-nine African traditional healers among the Bagandas of Uganda were interviewed to explore their beliefs about mental illness; all of them reported a belief that it was caused by evil spirits, witchcraft, or curses (Ovuga, Boardman, & Oluka, 1999). Similarly, in a study to evaluate lay beliefs regarding the causes of mental illness in south-west Nigeria, Adewuya and Makanjuola (2008) found Nigerian rural dwellers to be more likely to endorse supernatural factors as causing mental illness, when compared with urban dwellers.

**Mental Health Help-seeking Behaviour**

Mental health help-seeking behaviour in a native African society usually involves a household decision-making process, very often influenced by the community’s concept of mental illness. Despite subjective reports of mental and physical health symptom presentation, African immigrants in this present study did not report engaging in help-seeking behaviours to aid in their concerns. It may be that, for these participants, the act of seeking mental health services is influenced by their personal beliefs about what concerns are stressful enough to require help from mental health professionals. This can reflect both structural and cultural barriers, including the lack of linguistically accessible services, a desire to deal with problems on one’s own, the
concern that the problem will not be understood by practitioners because of cultural or linguistic differences, and fear of stigmatization (Whitley et al., 2006).

Mental health help-seeking behaviours among the African immigrant respondents were covert. Mental health stressors and issues were not discussed because of attached cultural stigma and these concerns were hidden, diverted and presented as physical symptoms that were more acceptable by society.

There is documented evidence that the manifestation of physical symptoms as a diversion to deal with mental health related issues is not unusual for minorities or other immigrant populations (Ali & Toner, 2001; Heilemann, Lee & Kury, 2002). Ali and Toner (2001) studied symptoms of depression among Caribbean-Canadian women. Some of their sampling criteria were similar to the current study as those participants were born in English speaking countries, and immigrated to Canada within the last five years. The results of the study indicated the women engaged in *self-silencing* as a means of dealing with depression. Brown, Abe-Kim, and Barrio (2003) conducted a study on manifestation of depressive symptomatology in three ethnically diverse groups of women (African American, Asian Pacific and Latino). The African American and Latino participants described impairment in physical functioning and placed great emphasis on somatic symptoms that may have contributed to lower detection of depression in this population. The Asian Pacific participants described symptoms such as “constricted, pushing up or oppressed sensation in the chest, palpitation, flushing, headache and irritability” (p. 13). The African immigrant respondents in the current study expressed symptoms such as migraine, palpitation, irritability, tense chest and poor concentration as somatic complaints, indicators that *something is going on with their mental health status.*
Cultural Appraisal

Cultural expectations and roles are considered important topics in immigrant communities because they have a vast impact on immigrants’ self-perception and acceptance within the host community. Any services designed to be responsive to the needs of cross-cultural clients must take into account factors such as an individual’s social and cultural influences. In discussing traditional treatment, Onyemaechi, (2000) stated that Indigenous cultures still practice many ancient techniques for healing mental and emotional illness. In Western society, healing is often considered to be a private matter between patient and/or participant and therapist. In Africa, healing is an integral part of society and of religion, a matter in which the entire community is involved. Within communities of African descent, psychotherapy is often perceived as a process that requires the client to “tell (his or her) business to strangers” and relinquish his or her independence (Priest, 1991, p. 214). Cultural objections to sharing information with individuals outside the extended kinship network encourages the resolution of personal concerns within the social network and discourages the pursuit of assistance outside of this group (Priest, 1991). This finding is consistent with the finding in the present study, as most respondents stated they do not like sharing their personal life with strangers. Furthermore, among people of African descent, historically based expectations that adversity will be endured and overcome through demonstrations of strength and pride may contribute to an implicit belief that seeking help is a sign of weakness, as evidenced by some respondents’ views that men are not supposed to show emotions, cry, or seek help as this can be viewed as a sign of weakness.
Stigma

Evidence shows that stigma attached to mental health is not uncommon in various cultural groups, both Western and non-Western. A study done in Canada that looked at how black West Indian Canadian women managed depression revealed that the women in the study would not admit to being depressed as they feared being stigmatized, particularly in their own group, and would be labeled as “crazy”, “insane”, “coo-coo” or “nuts” (Schreiber, Stern, & Wilson, 1998). The African immigrant groups in this study are no different, as many of the participants describe a person suffering from mental illness, or experiencing a mental health stressor, as mad, crazy and weird. The women in the Schreiber et al. (1998) study talked about the predominant consequence of being shunned if they admitted to their depression. The consequences discussed by respondents of the current study were similar in that they were not only shunned but described as cannot be trusted, should be feared, should be isolated.

Resources

Resource availability was a major recurring concept that emerged within the cluster of substantive themes, such as social/environmental resources, personal resources, and cultural appraisal. Deciding whether to take action about health concerns, and if so, how to take action, is influenced by an individual’s background and beliefs in conjunction with their positive and negative experiences with health care. Research has shown evidence that there is a differential pattern of use and response to mental health services among ethnic clients (Brown et al., 2003; Myers et al., 2002; Thompson, Bazile, & Akbar, 2004). There is limited visible or overt mental health seeking behaviours and thus there is a significant gap in utilization of mental health services. In the current study, only two participants sought the help of a counselor to handle their
emotional stressors. Kirmayer et al. (2007) conducted a study in Montreal, Canada, on the use of healthcare services for psychological distress, with a random sampling of 924 Canadian-born individuals and 776 new immigrants. It revealed that the rate of health services use for psychological distress was lower among immigrants (5.5% compared to 14.7% for Canadian-born individuals). Conversely, the second major factor that dissuades mental health treatment-seeking is lack of adequate knowledge of mental illness and resources available in the community. In the present study almost all participants stated they did not know where to go for mental health resources. At the societal level, culturally sensitive and specific mental health services prove the best approach towards positive mental health outcomes. Despite good intentions, services remain underused when formulated without a contextual understanding of the clients for whom they are intended (Newbold, 2005; Whitley et al., 2006).

O’Mahony & Donnelly (2007) conducted a qualitative study which explores how contextual factors intersect with race, gender, and class to influence the way in which immigrant women seek help to manage their mental illness. It also attempted to identify which interventions were most effective in meeting the mental health needs of immigrant women. The study found that barriers to mental health services include inefficient language skills, unfamiliarity of services, and low social economic status. This finding is consistent with the present study in which almost all respondents raised mental health services and language as major issues. It was concluded in the previous study that gender roles limit immigrant women’s accessibility to mental health care, whereas in the present study gender was not an issue. Healthcare providers need to recognize and facilitate the removal of structural barriers that immigrants face when seeking care.
Coping Responses

This study found that African immigrants were more likely to use prayer or meditation, in addition to finding comfort in their religion or spiritual beliefs, as a means of coping with stressful life events. These results add to overwhelming support from previous research that highlights the importance that religion and spirituality play in the daily lives of African immigrants. A study by Van Olphen et al. (2003) revealed how spirituality can help to reduce depressive symptoms and positively impact one’s overall health. Additionally, merely attending church, and being in the presence of people with similar beliefs and stressors, can serve as a major source of ongoing support for African immigrants. Sorsdahl et al. (2009) found that 49% of their Black South African study respondents reported consulting with religious and spiritual advisors. Clergy in these churches cultivate belief in the supernatural. These beliefs are usually not compatible with Western health belief models (which attribute the presence of illness to biological and environmental factors, usually excluding supernatural involvement), making it all the more difficult for most African immigrants suffering from mental health problems to seek help from qualified professionals.

Cultural mistrust is another issue that most respondents dwell on when dealing with mental health issues. Some of the respondents believe that mental illness can be controlled with treatment and counseling. They were, however, ambivalent and apprehensive about the use of medication to control mental illness, mainly because of side effects. Their concern is supported by a recent study in which it was found that African Americans were more likely to receive newer, safer, and more tolerable serotonin reuptake inhibitors (SSRIs) for depression (Melfi, Croghan, Hanna, & Robinson, 2000). This could be attributed to fear of side effects and mistrust of the healthcare organization.
Personal Resources

An overwhelming majority of respondents in this study, who had experienced mental and physical health symptoms, indicated that they had sought help from either social supports (family, friends, roommates) or nobody. This pattern of low utilization of mental health services by African immigrants has been explained in various ways. Among African societies, Jegede (1981) suggested that usual health-seeking behaviour is that the patient first seeks help from traditional sources (spiritual sources) and lastly from health professionals. Due to this general practice of using traditional and home remedies, Africans may be more comfortable with this avenue and seek it out first, before consulting with mental health professionals. Furthermore, in most African communities, Africans are used to taking care of problems by being there for each other, and they seek assistance from religious/spiritual leaders and community elders, as opposed to doctors or therapists. In the study by Constantine et al., (2005), African international students expressed their scepticism of the usefulness of confessing their problems to strangers. A study conducted by Erickson and Al-Timimi (2001) on Arab immigrants showed that family is the centre of their social environment and social organization, therefore, during an illness or crisis individuals may depend heavily on other family members for support and help in coping. This behaviour was similar to that of respondents in the current study. Hence, due to this interdependency and extensive family network, Arab Americans may tend to be reserved initially in dealing with individuals from outside their social network, particularly in seeking professional mental health services.
Implications for Future Research

Inclusion of ethnic minorities into mental health research has been strongly recommended to improve the knowledge base regarding ethnic minority mental health. In doing so, the findings of this study argue for further research with a random and large sample of African immigrants, that could explore the way social support networks, stigmatizing beliefs about the mentally ill, and attribution about mental illness, operate to affect attitudes toward seeking mental health services. The following additional recommendations are made based on the findings of this study:

1. Replication of the present study including participants who have been diagnosed with a mental illness
2. Replication to non-African immigrants to determine if participants’ responses would be similar
3. Using a quantitative method of inquiry to control for variables such as age, length of time in the host country, educational level, and marital status

Implications for Nursing Practice and Policy Makers

Issues related to immigrants’ mental health are fundamental to Canada’s immigration policy development. First, the mental health of immigrants is an important determinant of general measures of population health, and therefore is directly related to issues of the cost and adequacy of Canada’s healthcare system. Second, the mental health of Canada’s immigrant population is an important determinant of the costs and benefits of Canada’s immigration policy, and relates to questions such as whether Canada is maximizing the return of its large-scale immigration programme. Differences in the rate of utilization of mental health services are
known to exist in different ethnic minority communities, highlighting the need to understand help-seeking in specific cultural groups, rather than lumping visible minority or ethno-cultural communities together. Thus, having an understanding of African immigrants’ mental health services utilization will facilitate the planning and delivery of preventative mental health services to this population, so that African immigrants will be encouraged to enter into the mental healthcare system before psychological distress becomes unmanageable. Furthermore, an understanding of help-seeking attitudes of this immigrant group can help to identify mental health needs, provide practitioners and policy makers with information regarding interventions and alternative resources which can add to, or complement, efforts to provide equitable and effective care to this growing community in many Canadian urban areas.

The findings of this study have implications for nurses and other healthcare professionals as they provide a framework for working with African immigrant populations. Nurses serve an important role in increasing African immigrants’ utilization of mental health services. However, barriers related to poor access to information and treatment need to be addressed. Nurses working in community and primary care facilities, when performing evaluations of African immigrants at risk for mental health issues, can educate and counsel these immigrants on symptoms of emerging mental health problems and help decrease the stigma attached to such issues. Nurses, in their role as educators, can address the stigma of seeking help by providing factual information about mental illness and mental health services options. Most discussions of immigration focus on human capital, usually translated as education and job skills. Health, like education, is an important component of human capital. Policy decisions have important and potentially far-reaching repercussions for new settlers. For example, most provinces impose a mandatory waiting period of three months for a person to qualify for health care. When the
waiting period is over there is a surge in immigrant health visits. The consequences of mandatory waiting periods, and their effect on decisions regarding preventive health care, require careful study.

Religious communities and cultural groups also might take the lead in establishing primary care programs and services that serve their respective populations. This can be achieved through collaboration between health authorities, service providers, and immigrants. Health, social and community agencies need to enhance their websites with comprehensive information describing if and how they accommodate the mental health needs of immigrants. African immigrants may be uneducated on matters pertaining to mental health concerns (Adewuya & Makanjuola, 2008). They may be unaware of the existence of psychological services that may be available within their community. One way to increase awareness about the availability of mental health services would be to encourage education about the detection of mental health problems and the availability of mental health services among African immigrants. It is, however, important to note that mere awareness of the availability of mental health services may not be enough to increase their utilization.

**Limitations.**

This is a qualitative study and relies on voluntary participation of respondents who self-identify themselves, hence the study captures only the experience of those who choose to participate. The experience of those who choose not to participate might be very different. It should also borne in mind that this a small sample size which will reflect the experience of African immigrants with a length of stay in Canada of five years or less. Hence, findings cannot be generalized to the larger African community. Another limitation was found in researcher
presupposition. In an ideal world, the researcher would be able to remove herself from the data under study. However, due to real world conditions and the inability of anyone to totally remove themselves from the investigation, some bias could creep into the study. Also, another limitation is that Africa is a large continent with various cultures. This might not reflect the broader views of all Africans in their respective countries. Additionally, the majority of respondents were from the eastern region of Africa. The snowball method of recruitment may have influenced the reachability of the study to African immigrants from a variety of African countries, especially if respondents’ social networks drew from individuals from their own countries of origin.

Conclusion

The purpose of this study was to explore the help-seeking behaviour of African immigrants living in Ottawa. The results of this study underscore the need for increased understanding of this group of the population as they navigate through the healthcare system. African immigrants who participated in this study experienced a number of immigration-related stressors. It is my hope that the findings of the present study will lead to implementation of culturally sensitive and competent programmes for African immigrants that take into account their values, norms, beliefs, and perceptions of mental health and mental illness. It is the researcher’s contention that more research studies need to be conducted to examine further the qualitative domains identified in this study, in particular, cultural adjustment issues, knowledge of availability of services, and stigma.
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APPENDIX A:
Flyer to Advertise Study and Recruit Participants from the African Community

Your participation in a research study is needed!

Are you a member of the African Community who:

- is 18 years of age or older
- has been in Canada for a period of 1–5 years
- can speak English

If so, we would love to hear from YOU!

You are being invited to participate in a research study directed by Safia Issack and Dr. Kevin Woo to investigate the experience of African immigrants’ help-seeking behaviour for their emotional and psychological issues. Learning about your experiences will help others to understand the needs of your community and to develop more culturally sensitive mental health services.

For more information and/or to participate in the study, please contact:

Safia Issack, BSCN, MScN Student at 12si14@queensu.ca
Appendix B:
Consent to Participate as a Research Subject

Title of Research Project: Help-seeking Behaviour Among African Immigrants for their Emotional and Psychological Issues.

Principal Investigator: Mrs. Safia Issack, RN, BNSC, MScN. Nursing student
Email: 12si14@queensu.ca

Co-Supervisor: Prof. Kevin Woo, RN, PD
Tel: 613-533-6000

You are being invited to participate in research that will be conducted by Safia Issack, a Master’s student in Nursing at Queen’s University. The study will explore to understand the help-seeking behaviour of African immigrants for mental health issues.

PROCEDURES

You will be asked to participate in an interview regarding your experiences with help-seeking behaviour of any emotional or psychological issues. Your participation in this research is entirely voluntary. You maintain the right to decline to answer any question or end the session at any time during the interview. You will not be required to disclose any personal information regarding your identity or any information that makes you feel uncomfortable. If you agree to participate in this study, I will set up a time and place at your convenience. The interview will be approximately last about one hour. If you feel uncomfortable signing the consent form with your full name, you have the option of initialing it. The interview will be audio taped, which you will be asked to verbal consent in the beginning of the interview as well.
POTENTIAL RISK AND DISCOMFORT

Some of the questions are personal and sensitive, and you may experience some discomfort answering them. If you feel that a particular question is too personal or causes discomfort, you may skip that question without any consequences. Your decision to participate in this study is entirely voluntary and you can choose to decline or withdraw from the study at any time without consequences of any kind.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

This research will not provide a direct benefit to you. However, the results of this study will provide valuable information to mental health services providers on how to better understand African attitudes towards seeking help for their mental and emotional problems. From this information, mental health services providers will have the opportunity to improve the quality of services and increase mental health services utilization for African Immigrants.

PAYMENT FOR PARTICIPATION

For your participation in this study, you will receive a $5.00 gift card to Tim Horton. You will be provided with a gift card immediately after completing the questionnaire. Additionally, if you or someone you know may be interested in receiving mental health services, the researcher can provide you with a list of mental health agencies in the local community. No additional compensation will be provided.

ANONYMITY

Any information that is obtained in connection with this study will remain anonymous and will be disclosed only with your permission or as required by law.
IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Safia Issack, Principal Investigator, or Dr. Kevin Woo, Supervisor. Safia Issack can be reached at 12si14@queensu and Prof. Kevin Woo can be reached at 613-533-6000

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights, or remedies because of your participation in this research study. If you have questions regarding your rights as a research subjects, contact Dr. Albert Clark, Chair, Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board at 613-533-6081.

CONSENT OF RESEARCH SUBJECT

I ________________________________ consent to participate in the research study entitled, Help-seeking Behaviour of African Immigrants for their Emotional and Psychological Issues. The researcher, Safia Issack, has explained the purpose of the study, the procedure to be followed, and the expected duration of my participation. The study is being conducted in partial fulfillment of the requirements for the MSc degree in Nursing at Queen’s University, under the direction of Dr. Kevin Woo, Professor of Nursing at Queen’s University.

I have been informed that the interview session will be audio-tape recorded and that these tapes will be locked in a cabinet when not in use and destroyed after the study is completed. I understand that a professor who is an experienced researcher and member of Ms. Issack committee may listen to section of the audiotape recording for supervisory purposes and that I
may refuse this action if I choose. I understand that at no time before, during or after the study will my identity be revealed to anyone other than the researcher.

I understand the procedures and conditions of my participation describe above. My questions have been answered to my satisfaction. I am at least 18 years of age.

By signing this consent form, I am indicating that I agree to participate in this study.

_____________________________________________  ______________________
Signature of Participant                          Date

_____________________________________________  ______________________
Signature of Person Obtaining Consent            Date

**To be signed by the investigator:**

I have carefully explained to the participant the nature of the above research study. I certify that to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risk involved in this study.

_____________________________________________  ______________________
Signature of Principal Investigator              Date
APPENDIX C:

Demographic Sheet

Demographic Information

1. Gender:

Male---------------- Female-------------------

2. Age-----------------

3. Country of Birth---------------------

4. Years of Residence in Canada------------------

5. Education Level

    Some High school-------- All of High School-------- College/ University--------

6. Marital Status

    Married------ Divorced------ Separated------ Single------

7. Type of Entry into Canada

    Independent immigrant-------- Refugee-------- Refugee claimant or other--------

8. Family income: a) 10,000 or less; b) $11,000–30,000; c) 31,000–50,000; d) $ 51,000–70,000

9. Living Arrangements:

    Living Alone-------- With Family-------- With others--------

10. Are you currently taking any medication: Yes------ No------

    If yes, which ones-----------------------------------------
Appendix C: Open-Ended Questions for the Interview

Main Question and Sub-questions

- Explain to me in your own words what does the term “mental health” mean to you?
- Describe to me some of the challenges you faced as new African immigrant living in Ottawa?
- What do you think causes mental illness? (prompts), have there been changes in the way you perceive mental health over years?
- Describe to me whether you ever felt overwhelmed when dealing with any emotional or psychological issues?
- Tell me about getting help for any mental health issues.
- When was the need to seek help identified and what kind of help was sought – (prompts) were any rituals, prayers or ceremonies part of the help-seeking in dealing with crises?
- Tell me about mental health resources you were able to access during your stay in Ottawa?
- What was the reaction of the people important to you/family members?
- What happened in your interactions with health professionals?
- Is there anything you would like to have been done differently, and if so, how?

Conclusion

Is there anything else you would like to add or share about this topic that you feel is important for me to know.