THE INFLUENCE OF DEGREE OF AFRONCENTRIC SPIRITUALITY ON

PSYCHOLOGICAL HELP SEEKING ATTITUDES, INTENTIONS

AND STIGMA AMONG NIGERIAN AMERICANS

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THE INFLUENCE OF DEGREE OF AFRONCENTRIC SPIRITUALITY ON

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Dissertation

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ABSTRACT

The study examined the relation between Afrocentric Spirituality and psychological help seeking attitudes, intentions, and stigma among Nigerian Americans. The researcher investigated whether stronger Afrocentric Spirituality was associated with weaker attitudes toward seeking psychological help, less intention to seek mental health services, and stronger self and other perceived stigma toward psychological help seeking. The sample included 122 adult first generation Nigerian Americans from three different states in the South and Midwest. Participants completed a demographic questionnaire, the Spirituality Scale (Jagers & Smith, 1996), the Perception of Stigmatization by Others for Seeking Psychological Help Scale (Vogel et al., 2009), the Self-Stigma of Seeking Help (Vogel et al., 2006), the Intention to Seek Counseling Inventory (Cash, Begley, McCown, & Weise, 1975), and the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (Fischer & Turner, 1970). Results from a multiple regression analysis indicated that there was no relation between Afrocentric Spirituality and help-seeking attitudes or self stigma about seeking mental health services. There was a positive correlation between Afrocentric Spirituality and other stigma, demonstrating that as Afrocentric Spirituality increased the perception of others' stigma (i.e., friends, relatives) about seeking mental health services also increased. Contrary to expectations, there was a positive correlation between Afrocentric Spirituality and intentions to seek psychological help, indicating that as Afrocentric Spirituality increased participants had a

stronger intention to seek mental health services for certain concerns. Follow-up

analyses were utilized to determine whether sample demographic characteristics (e.g.,

level of education, socioeconomic status, income, and age immigrated to the United

States) were related to Afrocentric Spirituality or help-seeking intentions. However, non-

significant results were obtained. Implications for counseling practice, theory, and

counselor education were presented, as were recommendations for future research.

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CHAPTER I

INTRODUCTION

The number of African immigrants to the United States (U.S.) shows a 2000%

increase during the last 40 years. This accounted for at least 3% of the country's

population according to Dixon (2006) and Lollock (2001). Among African citizens,

statistics continue to show an increasing trend in the number of Nigerian citizens

immigrating to the U.S. (United States Census Bureau Report, 2004). For this study, the

term Nigerian Americans is used for consistency, with references to other racial groups in

the U.S. (African Americans, Asian Americans, Hispanic Americans, Filipino Americans

and Euro-Americans). A Nigerian American will refer to U.S. citizens who are or

descend from immigrants from Nigeria. It has been noted that Nigerian Americans are

found in all aspects of the American fabric including academia, manufacturing, and the

health care industry. For example, recent surveys show that Nigerian Americans are at

par or outperform other groups such as the Hispanic, Asian and Euro Americans (Ogbaa,

2003; United States Census Bureau, 2006, 2008).

Nigerians had previously come to the U.S. for educational opportunities in both

graduate and undergraduate levels. However, this changed in the early 1980s when the

political and economic situations in the country were volatile, leading many Nigerians to

stay back in America after their education while many more immigrated. It was noted

that a large proportion of those who left Nigeria were mainly professionals and the

middle class in general. This trend also showed that nuclear families migrated with the

purpose of settling in the U.S. (Ndubike, 2002; Ogbaa, 2003). Currently in the U.S.,

Nigerian Americans can be found in all facets of the nation's economic/business, social,

medical, and academic institutions. The data noted that 43.5% were in the educational

and healthcare industry. Sizeable communities of Nigerian Americans are concentrated

in the following states: Maryland, New York, Texas, Georgia, New Jersey, Illinois,

California, Ohio, Michigan, and Virginia (Ogbaa, 2003; United States Census Bureau,

2010).

       Although Nigerian Americans are often grouped with African Americans more

globally, they should be recognized as immigrants with a unique socio-cultural history, as

a different subset of African descendants. In this respect, Nigerian Americans may face

unique social and psychological challenges that can impact their global wellbeing. In

particular, Nigerian Americans use spirituality when coping with social and

psychological stressors. Because spirituality is a core component of Nigerian life, it is

reasonable to hypothesize that Nigerian Americans utilize their spiritual traditions as

means of coping with daily life problems, rather than more formal Western approaches to

psychological health such as seeking help from a mental health professional.

       The impact of immigration on the psychological wellbeing of the immigrant has

been well documented. Different studies and researchers have sought to understand how

this impact may affect the immigrants' perception of and attitude toward seeking

psychological help. Variables such as acculturation, gender, spirituality, socioeconomic

status, stigma, cultural values and level of education have been implicated and these

variables are likely to impact the Nigerian American person (Nwokocha, 2010; Okafor,

2009; Thomas, 2008). Psychological help-seeking attitudes may be one effective means of understanding and negotiating these unique challenges faced by Nigerian Americans. This is because knowledge and effective acculturation experiences will likely lead to good and positive prognosis as well as a reduction in mental health costs over time (Mo & Mak, 2009).

Psychological help seeking can be described as seeking mental health assistance from a professional. There are however, other nontraditional methods besides counseling that people have been known to use all over the world for example prayer, local charms and amulets (Angermeyer, Matschinger & Riedel-Heller, 2005; Graham et al., 2005; Henry & Kemp, 2002). In an attempt to understand the nature and concept of psychological help seeking, researchers have noted different aspects to this concept. For instance, it has been conceptualized as a process which an individual goes through (cognitively and psychologically) before deciding to either seek counseling or not (Thomas, 2008). This process is influenced by factors such as social contexts and spiritual experiences and beliefs (Ally & Laher, 2008; Henry & Kemp, 2002). To this end this study investigated the influence of degree of Afrocentric Spirituality on psychological help-seeking attitudes, intentions, and stigma among Nigerian Americans.

Nigerian Americans and Help-Seeking Attitudes

Persons, including those of African descent are seeking mental health assistance at an ever-increasing rate (Oliver, Pearson, Coe, & Gunnell, 2005; U.S. Surgeon General, 2000). Further, the decision to do so may depend upon factors such as race, attitudes, gender, age, acculturation and cognitive disposition (Baello & Mori, 2007; Diala et al.,

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2000; Sheu & Sedlacek, 2004; Thomas, 2008 (Fung & Wong, 2007; Givens et al., 2007). The *Merriam Webster's Dictionary* (2004) describes attitude as one's conceptualized position or feeling with regard to a fact or state. In other words, an individual's willingness to seek psychological help may depend upon attitude toward the source of help, perceived efficacy of this source, and perhaps trust and comfort with the source(s) of help. There seems to be some reasonable amount of literature on attitudes toward psychological help seeking among other ethnic minorities such as African Americans, Asian Americans, and Hispanic Americans compared to the Nigerian American population as discovered in the current research

Two aspects that have been shown to affect attitude to seeking professional psychological help are race and ethnicity. Results are, however, not fully consistent. For instance, one study showed that other ethnicities besides Euro-Americans underutilized mental health care (Dadfar & Friedlander, 1982), while another showed that African Americans were more likely than other ethnic groups to utilize mental health services (Sheu & Sedlacek, 2004). Asian Americans seem to be traditionally perceived to not seek psychological and psychiatric help except during crises (Maki & Kitano, 2002; Mo & Mak, 2009; Sue & Sue, 2008) but have been observed to overuse vocational and academic services. Cautionary to these findings is that Asian Americans (just like the Africans) comprise distinct subgroups that differ in religion, language and values (Maki & Kitano, 2002). Further, another observation seems to be process related. For example, Ramos-Sanchez and Atkinson (2009) reported that as Mexican Americans lose their culture of origin, their attitude toward help seeking becomes less favorable while adherence to traditional Mexican culture and values actually encouraged help seeking.

Sue and Sue (2008) argued that other factors such as racism and acculturation difficulties may be to blame. Some researchers have shown that symptoms' severity could be another factor (Oliver, Pearson, Coe, & Gunnel, 2007).

Studies on African immigrants and specifically the Nigerian population in the U.S. and Europe indicate that they experience psychological distress that may be complicated with unique adjustment and acculturative issues (Majid, 1992). It is not clear whether Nigerian Americans specifically seek psychological help to a large extent. However; it has been documented that Nigerian immigrants do experience mental health issues such as depression (Ezeobele, Malecha, Landrum, & Symes, 2010) and have sought help variously. These included medical help given by physicians (Thomas, 2008) and in colleges for academic and adjustment issues related to work and school/career (Essandhoh, 1992 [cited in Thomas, 2008]; Idowu, 1995). These revelations support Thomas's (2008) findings that West African immigrants were more likely to seek help first during crises and through means other than counseling. Possible explanations have been offered for these findings ranging from attitude to and perception of mental health and culture/stress-related experiences. Ezeobele et al. (2010) noted that belief about what caused mental illness and stigma of mental illness were also implicated in treatment attitudes. One question is: what is the attitude of Nigerian Americans toward psychological help seeking? The few studies found to date indicate that Nigerian Americans' attitude toward psychological help seeking may not be different from that of the other ethnic minorities (Ezeobele, 2010; Maki & Kitano, 2002).

As immigrants to the U.S., Nigerian Americans may still harbor the negative attitudes culturally displayed toward mental illness and as such whatever treatment

processes accorded to it. A recent online article about the state of mental health in Nigeria stated that the refusal of the lawmakers to consider the Mental Health Act is in part a reflection of public attitudes toward mental health in our society (Abati, 2008). It is safe to say that culturally enshrined beliefs about mental illness and its etiology, among Nigerians and possibly even those living in the U.S., may be reasons negating attitudes about psychological help seeking.

Findings by Gureje, Lasebikan, Oluwanuga, Olley, & Kola (2005) revealed poor knowledge about what causes mental illness with majority of the sample believing that those who were mentally ill were likely to be violent. Ogunsemi, Odusan and Olatawura (2008) reported similar findings with a sample of medical students who had previous exposure to psychiatry. The study showed that the attitude was more negative when someone was labeled as mentally ill. Similar results were noted from other studies done with Nigerian populations, for instance, Adewuya and Oguntade (2007) and Kabir, Iliyasu, Abubakar and Aliyu (2004) among adults in Northern Nigeria, and Ezeobele et al. (2010) among Nigerian American women living in the U.S. It is, therefore, safe to hypothesize that psychological help seeking could be compromised with this kind of attitude toward mental illness. Here in the U.S., Thomas (2008) noted that West Africans (including Nigerian Americans) did not utilize the mental health care rather they were more inclined to use informal sources such as family, friends, pastors, and natural remedies. Another study by Nwokocha (2010) of West Africans (includes those living in Northern California supported this observation. Okafor (2009) noted that among Nigerians living in the U.S., SES, gender, level of education, and duration of stay in the U. S. did impact attitude toward counseling.

Another factor that may further impact psychological help-seeking attitude is symptoms report. Researchers have long observed that non-Western individuals tend to report psychological symptoms in physical terms or descriptive similar to the Freudian and Jungian somatization and dream principles (Idemudia, 2004; Nadeem, Lange, & Miranda, 2008; Thomas, 2008; Ying & Miller, 1992). Edigbo and Ihezue (1982) observed that Nigerians who were depressed complained of heaviness in the chest, which may be panic attack, and crawling sensations and/or burning in the body such as the head, belly, legs or arms. Symptoms manifestation and conception may predispose this study population to seek medical care for psychological problems noted Thomas (2008). Also, it may be easier to seek medical care for fear of stigma attached to mental illness as well as mental illness conceptualization among people of African descent (Ezeobele et al. 2004).

Nigerian Americans and Help-Seeking Stigma

The idea of stigma seems to be an old and established phenomenon. It appears to pervade most human societies and always reflected and perceived negatively. In fact the word stigma which has its origin from the Greek language means a slave or a non-person. "The marks of crucifixion which appear on Christian saints hands and feet known as the stigmata signifies a disgrace or defect" wrote Gray (2002, p. 72). Goffman defined stigma as a trait which is deeply discrediting, an interactive social process (cited in Byrne, 2000; Gray, 2002). This concept was articulately defined by Link and Phelan (2001). They wrote:

> Finally stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the

construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion and discrimination. Thus we apply the term stigma when elements of labeling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows the components of stigma to unfold. (p. 367)

Implicit in the above description is that stigma is not culture free nor is it a biological trait. It is rather a process-encoded phenomenon in the human psyche over time and it pervades every race (Anglin, Link, & Phelan, 2006), culture, and society (Gary, 2005). Because stigma is perceived differently across cultures, the mental health profession may use this knowledge to work on finding effective ways to engage clients of different worldviews "culture" during counseling (Sue & Sue, 2008).

The impact of stigma includes low self-esteem and a sense of shame and isolation (Byrne, 2000; Gray, 2002). It also poses a problem when physical and mental health are indicated (Ward, Mertens, & Thomas, 1997) since it has been shown that there is a connection between self-concealment and help-seeking attitudes (Vogel & Armstrong, 2010). It is hoped that as research on mental health and illness expands, its influence on psychological help seeking and even the public in general will improve for the better. Hence, in the mental health profession, researchers have sought to understand how stigma relates to psychological help-seeking processes (Vogel & Armstrong, 2010).

Wallace and Constantine (2005) found that in the African American population, those who showed a higher degree of Afrocentric values were associated with greater perceived stigma about counseling. Following similar findings; Anglin et al. (2006) noted that although African Americans were more likely than Euro Americans to believe that mentally ill people would be violent toward other people; they were less likely to agree that they should be punished for their behavior. Similarly in a study by Okonkwo,

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Reich, Alabi, Umeike, & Nachman (2007), a sample of pregnant Nigerian women was investigated to ascertain their beliefs about and attitudes toward voluntary counseling and HIV testing. The authors found that 69% of those who refused attributed their decision to the social and cultural stigmatization associated with HIV. Ogunlesi (1999) found that Nigerians who suffered from mental illness and their families believed that mental illness was caused by both heredity and supernatural forces.

These findings show a relation among beliefs about what causes mental illness, behavior toward those with mental illness, and consequently the kind of treatment perceived to be appropriate. One may argue then that if mental illness and associated stigma were of strong cultural and cognitive schemas, then seeking professional psychological treatment would be counterintuitive. This may explain why the preferred mode of treatment for mental health among Southwestern Nigerians included spiritual and traditional healers after physicians help (Adewuya & Makanjuola, 2009). Similar results were found among South Africans (Ally & Laher, 2008) and East Africans in Zambia (Sikwese et al., 2010)

Nigerian Americans and Help-Seeking Intentions

Intent to seek counseling with regard to mental health is another factor in understanding influences that may impact psychological help seeking and associated processes. Studies have shown that intention to carry out an action or behavior often resulted in actuality (Mo & Mak, 2009; Stanton et al., 1996). However, intention cannot be perceived as occurring in a vacuum; rather it is a complex series of interactive processes occurring both within and outside of the individual. As such, it is influenced

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by external processes such as the socio and cultural contexts within which the individual resides (Angel & Thoits, 1987).

Vogel, Wester, Wei, and Boysen (2005) investigated the role of outcome expectation and attitudes on decision to seek professional help and found that psychological factors and attitudes far more predicted intention to seek help for interpersonal problems compared to specific problem such as drug use. They also found that anticipated outcome of talking with the counselor was associated with use of psychological services.

Intention to seek counseling among the African American population can be inferred from other variables investigated in relation to mental health help seeking. Reasons such as lack of trust toward mental health professionals, service access barriers such as transportation and lack of knowledge about mental health resources and availability and beliefs about mental illness, and stigma have all been identified. It can be hypothesized that these barriers could affect one's intention to seek counseling.

While these findings are not unique to this population, their influence cannot be underestimated. One study showed that people who espoused Afrocentric values (that is, the extent to which an individual adheres to a worldview emphasizing communalism, unity, harmony, spirituality, and authenticity) were not likely to consider seeking psychological help (Wallace & Constantine, 2005). Due to the degree of family/ community influences in individuals' life within this population, the impact of others' expectations and/or suggestions have been known to be indicative of whether they sought mental health assistance during crises. For instance, Goddard (2002) and Gullate, Brawley, Kinney, Powe, & Mooney (2010) established that individuals were more likely

to seek help if significant people suggested it. Bagley (2002), however, found that intention to seek psychological help did not come up even in crises situation for the African American studied population.

There was no specific study found on the Nigerian American population with regard to intention to seek psychological help. However, prior reviews indicating the influence of stigma and attitude toward mental health in general may be indicative of intentions given the outcome results. Also, in one unrelated study economic status and education level were positively associated with seeking treatment from a formal source rather than an informal source (Mmari, Oseni, & Fatusi, 2010), which may be significant influences on intention to seek counseling among Nigerians Americans.

Spirituality and Help Seeking Among Nigerian Americans

Spirituality has been conceptualized as a relationship with a higher power, a somewhat personal process, and not requiring any form of organized or formal setting and tenets aimed at helping the individual transcend daily exigencies of life (Miller & Thoresen, 2003; Paris, 1995; Jagers & Smith, 1996). The influence of spirituality on health beliefs and psychological wellbeing has been established (Stanard, Sandhu, & Painter, 2000; Walker, 2009). Although spirituality is known to help people cope with many kinds of life experiences (Hill, 2009), its influence on psychological help seeking appears to be scantily researched. It was found in one study that both African Americans and Black Caribbeans were more likely to accept the importance of spirituality in their life (Taylor, Chatters, & Jackson, 2009). Figueroa, Davis, Baker, and Munch (2006) found that African American females were more likely to use a combination of prayer,

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home remedies, and medical help when ill. This supported Mansfield and Mitchell's (2002) findings that African Americans were more likely to believe that God acts through physicians.

Other sources of spiritual support that have been identified by African American cancer survivors included God, members of their religious community, family, friends, and health care providers. The subjects described these as contained in their definition of spirituality because of their experiential nature (Roff, Simon, Nelson-Gardell, & Pleasants, 2009). Spirituality has also been shown to impact not only illness outcomes but also whether patients sought treatment on time. For example, in a study sample of African American female churchgoers who were sick with breast cancer, it was found that those who believed solely in God, adopting the mindset that God alone would take care of their health were not inclined to tell people of their symptoms and as such their treatment process was delayed, while those who confided in others sought treatment sooner (Magee-Gullatte, 2010). The question then could be whether people thought about their spirituality when considering help seeking or formal mental help seeking in general.

Paris (1995) noted that the effects of religious practices on the mental health of immigrant populations may be complicated by institutional and individual relationships to the host society. Samouilhan and Seabi (2010) noted that a significant number of South African citizens hold traditional and spiritual beliefs regarding health in general and mental health in particular. Similar results have been replicated in Europe by Angermeyer, Breier, Dietrich, Kenzine, & Matschinger (2005), whose sample population reported that they believed mental illness to be a form of punishment from God.

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Samouilhan and Seabi (2010) explained that African world views subscribe to the idea

that mental illness (like all other illnesses) is caused by witchcraft, by a failure to connect

spiritually with the ancestors, God, and or with other members of the community or by

the removal by the ancestors of their protection over the person. It is safe to say that it

would be difficult for a person with this kind of mindset to seek professional

psychological help (Okafor, 2009).

One way to understand psychological help seeking in relation to spirituality

among Nigerian Americans may be to articulate African-centered spirituality. African

spirituality is rooted in the belief that all things in the universe are interconnected and

function in unison. Problems result when the individual or group is out of balance with

the cosmos (Paris, 1995). This belief has been explored and articulated comprehensively

by African scholars and writers including Jarvis et al. (2008), Mbiti (as cited in

Washington, 2008). The consensus is that African-centered philosophy is intertwined

with every aspect of the individual; hence, social and cultural experiences cannot be

separated or compartmentalized when treating the African person (including the Nigerian

American). Because of this belief, mental health or illness is construed differently from

the popular European disease concept. For example, mental health may be viewed as a

balance between the self, others, and the cosmos while illness may be conceived as being

out of balance with everything else including nature, self, and others. A study by Oladipo

and Balogun (2010) showed that Nigerians were likely to seek spiritual help for mental

health issues such as anxiety similar to what has been observed among other ethnicities in

the U.S. with some exceptions to Euro Americans. Also, Ally and Laher (2008) reported

similar findings among South Africans. They were likely to believe that mental illness

was caused by supernatural forces and therefore would prefer to seek help through other means than formal counseling.

Given that Nigerian culture and spirituality are intertwined, it is safe to suggest that spirituality may have a significant and potential impact on psychological help seeking among Nigerian Americans. Nigeria as a nation and people culturally espouse African ways of life that emphasize the importance of family and community in the life of individuals as well as belief in the presence and influence of the supernatural on the life of a community. To this end, family would likely be an avenue for mental health solutions but the experience of living in the U.S. may also change this dynamic. Okafor (2009) and Nwadiora (1996) noted that in the Nigerian culture, religious leaders (both orthodox and traditional) were influential in peoples' lives including their mental health and physical wellbeing. Similar trends were observed among Nigerian Muslims in the United Kingdom who tended to rely on their imams for guidance (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001). Oladipo and Balogun (2010) found that Nigerian women sought support from their pastors for all kinds of problems including marital ones. Given the concept of stigma and beliefs about the causes of mental illness among Nigerians, one can hypothesize that spirituality may influence psychological help seeking among this population and therefore is a pertinent factor to consider when rendering counseling services.

Statement of the Problem

Research shows that a complex interaction of variables (stigma, attitudes, intentions and spirituality, and socio cultural contexts) impacts whether an individual

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seeks help in general and specifically mental health treatment. Two studies found to have

investigated similar constructs among West Africans and specifically Nigerian

Americans were Okafor (2009) and Thomas (2008). Both studies were useful because

they specifically sought to study mental health attitudes of African immigrants (including

Nigerians) living in the U.S. with regard to demography, acculturation, and mental health

issues. Thomas (2008) explored the attitude of African immigrants to the U.S.

highlighting their cultural and adaptation processes including seeking mental health

support. Okafor (2009) highlighted the cultural life of Nigerians and intimated why they

may be resistant to psychological help seeking which they may perceive as impersonal

and invasive. This researcher went on to discuss mental health practices in Nigeria

including help seeking from religious leaders such as church pastors and also traditional

healers from indigenous African healers. An important revelation from Thomas (2008)

was the confirmation that African immigrants do seek psychological help but mainly

from physicians and not psychologists or counselors. Okafor, on the other hand,

established that demographic factors significantly predicted the need for Nigerian

immigrants in the U.S. to seek professional counseling; demographic factors did not

predict stigma tolerance among Nigerian Americans. Although data suggested that

demographic factors predicted openness toward seeking counseling for this group, only

socioeconomic status had significant influence when subjected to follow-up analyses.

　　　While both studies explored some cultural and social issues which African

immigrants experienced, neither of these studies further examined relations among

psychological help seeking, observed cultural implications, and specifically spirituality.

That is, neither examined the role that Nigerian spirituality plays in psychological help-

seeking attitudes, intentions, or stigma. This is pertinent because spirituality as a variable is central to African culture and way of life. It is known already that there are correlations between attitudes, intention, and stigma toward seeking counseling among other ethnic Americans (Bagley, 2002; Deane, Stogstad, & Williams, 2009; Fung & Wong, 2007; Nadeem et al., 2008).

This research attempted to examine the relations between degree of Afrocentric Spirituality and psychological help-seeking attitudes, intentions, and stigma among Nigerians Americans. It is safe to assert that as a result of this deficit in the literature, researchers may continue to see underutilization of mental health services due to lack of knowledge about how it works, distrust of mental health professionals, socioeconomic reasons, and other aforementioned logistics. It is believed that with multicultural counseling noted as the fourth force in today's counseling profession, counselors may be lacking in competence when it comes to working with Nigerians. An exploration of the influence of spirituality on the cultural life of Africans and its subsequent importance in how decisions about health in general are made will likely impact counselor education and training and subsequently skills and theories adaptation.

Purpose of Study

The purpose of the study was to inform mental health professionals of the impact of Afrocentric Spirituality on psychological help seeking among Nigerian Americans. Specifically, the present study investigated whether Afrocentric Spirituality is related to psychological help-seeking attitudes, intentions to seek help or self or other stigma toward help seeking among Nigerian Americans. This will help counselors become

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culturally informed and at the very least assist them in educating Nigerian American clients whose mental health may be impacted by these variables. It will help counselors and other mental health professionals in providing more culturally relevant therapy to this client population.

Research Questions

The following research questions were addressed in this study:

Research Question 1: Is there a relation between Afrocentric Spirituality and attitudes toward seeking psychological help among Nigerian Americans?

Research Question 2: Is there a relation between Afrocentric Spirituality and intentions to seek psychological help among Nigerian Americans?

Research Question 3: Is there a relation between Afrocentric Spirituality and self or other-perceived stigmas toward psychological help seeking among Nigerian Americans?

Definition of Terms

African Worldview: The idea that traditional and cultural life of people of African descent is deeply rooted in their perception and belief in the natural order of things.

Attitude: May be described as a settled way of thinking or feeling that is reflected in a person's behavior. It may also be interpreted as a predisposition or tendency to respond positively or negatively toward an idea, object, person or situation.

Psychological help: Services or help provided by a mental health counselor, psychologist, social worker or psychiatrist.

Psychological help seeking attitude: May be described as a predisposition to seek psychological help.

Psychological help seeking intention: May be described as a plan or aim to seek psychological help.

Spirituality: Awareness and belief in the presence of the Spirit.

Stigma: May be described as a mark of disgrace or shame associated with a particular circumstance, quality or person. In this instance, related to seeking psychological help.

Worldview: May be described as a set of assumptions and presumptions that a person holds consciously or unconsciously about how reality is perceived.

Summary

This chapter introduced the Nigerian American client within the context of American history. It gave a description of statistics trends on Nigerian Americans, including where they can be found in the U.S., as well as what they may be doing. This chapter also informed how the Nigerian American individual may potentially articulate mental health issues, including attitude, etiology, and stigma about mental illness originating from Nigerian culture and way of life. Spirituality was discussed as the central element that may influence the Nigerian Americans conception of mental illness and treatment seeking thereof. Other studies were used to set the basis for this current research. Finally, three research questions were posed as pillars of exploration and guide for this current work. It was asserted that this would enrich mental health workers perspectives when working with Nigerian American clients.

CHAPTER II

REVIEW OF THE LITERATURE

An Historical Perspective

This chapter presented an historical perspective on Nigerian Americans discussing their exodus from Nigeria into the U.S. It also discussed Nigerian culture and worldview including spirituality, asserting that spirituality is intertwined with the cultural psyche of the Nigerian Americans and as such encompasses every aspect of life (family, roles, religion, childrearing, death). For this reason, mental health cannot be viewed in isolation from how it is conceptualized from the African centered perspective. As previously stated, Nigerians Americans are citizens of the U.S. who are or descend from immigrants from Nigeria. It appears that Nigeria's first contact with the United States (U.S.) dates back to the 1400s when Nigerians were brought to the U.S. as slaves who were later freed. Some of these freed slaves were not able to connect with their origins and included other Africans and together they constitute the African American ethnic group.

The history of what is current Nigeria began when it was created as a territory of Great Britain and named by Sir Fredrick Lugard after the river Niger in the mid-1900s. Although the country is made up of 250 ethnic groups and 510 languages, English is the official language declared by the British (Coleman, 1958; Ogbaa, 2003) to facilitate cultural and linguistic unity of the country. It is, therefore, not uncommon to see many

bilingual or multilingual Nigerians being fluent in English and other languages spoken in the country. Oral traditions and archeological discoveries of artifacts excavated by British archeologists, anthropologists, and historians show that Nigeria began as a closed society dating as far back as 400 B.C., with very little contact with the outside world and survived mainly through agriculture and metal and wood works (Coleman, 1958; Ogbaa, 2003).

Ogbaa (2003) noted three distinct phases of Nigerians' immigration after the initial history of slavery. Nigerians came to the United States in the mid to late 1900s solely for the purpose of acquiring American education. During this period, Nigeria was still a British colony; hence, her subjects were able to obtain visas to the U.S. Also in this era, there were different groups from various European countries working in Nigeria. This further established a Western presence in the territory. British merchants and Christian missionaries established schools and businesses. Their presence influenced the social and cultural life of the country as they continued to educate and inform Nigerian citizens in Western ways of living and economics. Nigerians who went abroad were noted to return home afterward with an expanded sense of the Western culture. The country benefited from Nigerians' experiences abroad, thus prompting the second wave of Nigerians who went to the U.S. for the same reason. As the citizens saw the value of Western education, more families and communities sponsored members to go overseas and study. Christian missions and other organizations also continued to encourage the idea. The third phase was marked by Nigeria's independence from Great Britain in 1960 and the establishment of the first indigenous university in Nigeria (The University of Nigeria Nsukka) by an American educated first premier of Nigeria. There was also the

Peace Corps program launched by John F. Kennedy in 1961. This encouraged more Nigerians to leave for studies in the U.S. (one goal of which was to help promote a better understanding of Americans on the part of the peoples from other cultures). Nigeria prospered fairly well as a nation having been endowed with natural resources, especially petroleum. By the 1970s, Nigerians who studied abroad came home to comfortable professional and academic positions helping to build the country. Nigeria was recognized as the fastest growing nation in Africa and even hosted an all-African cultural festival. However, the economic and political climate changed for the worse around the 1980s, negating the exodus of many Nigerian citizens to Europe, Great Britain, and the U.S. Most left with their families or sent for them as soon as they could (Amayo, 2009; Ogbaa, 2003).

Nigerian Americans tend to reside in larger cities such as New York, Houston, Baltimore, Philadelphia, Chicago, Boston, Los Angeles, to mention but a few. Okafor (2009) noted that unlike other ethnic minorities who tend to live in clusters and communities, Nigerian Americans are found living within and or among other ethnic groups and sometimes alone. It is, therefore, difficult not to find Nigerian Americans in any of the states of the U.S. They also form associations to encourage and support one another. Currently in the United States, Nigerian Americans can be found in all facets of the nation's economic, social, medical, engineering, and academic institutions. Although they are often grouped with African Americans more globally, they should be recognized as immigrants who immigrated with a unique socio-cultural history, as a different subset of African descendants.

African Worldview

In order to understand Nigerians' mental wellbeing, this section discussed some

salient cultural factors and worldviews that may continue to impact their life and mental

health in the U.S. This is because, in African culture, religious and spiritual beliefs

inform all other worldviews, behaviors, and practices (Mbiti, 1999). The traditional and

cultural life of Nigerians is deeply rooted in their perception and belief in the natural

order of things. Hence, no aspect of one's existence (birth, marriage, age group,

activities, and death) is treated nor lived in isolation or as distinct from common everyday

experiences. This is very important when conceptualizing mental health needs and or

treatment. As Wheeler, Ampadu, and Wangari (2002) stated: "An awareness of the spirit

is instilled from a very young age and reinforced through daily practices" (p. 77). The

Nigerian culture derives from an integrated system of social, psychological, and spiritual

phenomena. This can be observed in ways the family, extended family, and the

community as a whole interact. Aspects such as spiritual values are essential to the well

being of the Nigerian person (Okafor, 2009) because every aspect of their life is rooted in

their spiritual belief and worldview (Lee, 2012; Mkhize, 2004).

The concept of a worldview has been described as a set of assumptions and

presumptions that a person holds consciously or unconsciously about how reality is

perceived. The African worldview consists of a Supreme Being, deities and spirits,

cosmos, community, knowledge/knowing and ethics, and therefore general spirituality in

daily life. Africans believe in the existence of a supreme being, a God who is perceived

as the creator and sustainer of the universe. Mbiti (cited in Olumbe, 2008) described God

with such attributes as the "excavator, cleaver, molder, carpenter, originator and

beggeter." God is revered as being omnipresent (is everywhere) omnipotent (all powerful), and omniscient (all knowing). God is also perceived as the provider, the one who provides rain to enable people to farm and animals or wild fruits for food; he is the provider of the ultimate gift- life (Paris, 1995).

Deities include smaller gods of the spirit world. These are lower than the omniscient God and act as media through which people offer sacrifices to the main God. The Afrocentric view of this God does not allow humans to communicate directly with the spirits (including dead ancestors and family members) and smaller gods, such as the god of harvest, forest, fertility, thunder to mention but a few, are media through which man can communicate to the main God. Some spirits are good and therefore worshipped while the ones perceived as evil are feared and avoided (Olumbe, 2008). The Cosmos is believed to be a total unity with no distinction between the visible and the invisible, the natural and the supernatural and human beings are seen as part of nature (Turner cited in Olumbe, 2008). Although created by the Supreme Being, the day-to-day running of the cosmos is the task delegated to the deities and the spirits. Although human beings were believed to be created by the Supreme Being, exactly how this came about varies among different African folklores and legends. The "living dead" are the ancestors. These are members of the society who have died and are revered because of the belief that they are alive but unseen. It is believed that they can influence the visible life of the living. The construct of the ancestors is also rooted in the belief that there is life after death. The traditional African society regards the community more valuable than the individual within the community. For this reason obligations to family and the community in general supersedes the individual's needs. The value of the individual person resides in

the community. "I am because we are" (Lee, 2012; Ogbaa, 2003; Olumbe, 2008).

According to O'Donovan (1996):

> Africans tend to find their identity and meaning in life through being part of their extended family, clan and tribe. There is a strong feeling of common participation in life, a common history and a common destiny. The reality in Africa may be described with the statement: "I am because the community is." (p. 4)

This worldview can be observed in the way the family and the community regard life's stages of development. Sacrifices, prayers, oblations, and celebrations accompany every stage of life and rites of passage including birth, adolescence, marriage, death, farming, seasons, and disasters.

The "Knowing/Knowledge" worldview emanates from the awareness that every behavior has consequence and as such children are encouraged to know about the world of spirits and ancestors. The need to avoid or not violate these forces are taught and imbibed from an early age. Such knowledge is taught by oral traditions and passed on from generation to generation. Also the understanding of ethics, of what is good and bad are based on the traditions passed down from the ancestors. Traditions form the rubric of the value system and everyone is expected to follow without questions. Rulers and the elderly people in the community are the custodians and enforcers of law and order. To go against these rules usually would incur some punishment (Lee, 2012; Olumbe, 2008).

Nigerian Americans and Afrocentric Spirituality

It is important culturally and in terms of mental health to discuss spirituality as it is practiced currently in Nigeria. In order to understand the Nigerian American's attitude toward psychological help seeking, a discourse into his or her spirituality perspective is

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pertinent. This is because the moral behavior of Nigerian Americans is influenced by their deep spirituality and worldview and this is regardless of religious orientation and or affiliation (Ogbaa, 2003; Paris, 1995). The terms Nigerian American and African will be used interchangeably in this discourse.

The quest by man to make meaning of life and death, and achieve harmony with existence within this cosmos has been the subject of scholars for many centuries and is also what the concept of spirituality appears to imply. By extension, social sciences including the fields of psychology and counseling have continuously sought to understand man within the context of his environment. And so, psychology and counseling tend to teach and aspire as goals (such processes and terms like congruence, wholeness, holism, and altruism, intrinsic and extrinsic sense of self and self actualization) personal growth and development for their clients (Corey, 2005; Ellis, 1976; Fromm, 1997). It is, therefore, not coincidence that the wholeness perspective and or spirituality are gaining grounds within the mental health industry (Carpenter-Song et al. 2010). Benner (cited in Stanard et al., 2000) asserted that:

> all persons are created as spiritual beings. To describe someone as spiritual and another as not, implies a difference in their degree of awareness of and response to the deep striving for self transcendence, surrender, integration and identity. (p. 2)

This same concept was also implored by Washington (2010) in an attempt to articulate spirituality from an African perspective. Further, Elkins, Hedstrom, Hughes, Leaf, and Saunders (cited in Stanard et al., 2000) identified various spirituality values such as:

> A confidence in life, a balanced appreciation of material values, an altruistic attitude toward others, a vision for the betterment of the world and a serious awareness of the tragic side of life. They also stated that it means living out these

values with discernable effects on oneself, others and nature and on one's relationship with a higher power. (p. 204)

The aforementioned definitions, values, and conceptualizations are similar to the African frame of reference of spirituality. According to Jagers and Smith (1996), spirituality is a worldview or fundamental organizing principle within African culture. It implies a relationship, somewhat personal and not requiring any form of organized or formal setting and tenets and containing sets of values all aimed at helping the individual person attain a sense of calm that transcends daily exigencies of life according to Paris (1995). Spirituality of the African people is tied in with who they are as a race, and as such African Americans have been described as more spiritual than Euro-Americans (Ani, 1994; Baldwin & Hopkins, 1990; Benson, Scales, Sesma, & Rochlkepartain, 2005; Blaine & Crocker, 1995; Krause, 2003; Walker & Dixon, 2002; Wheeler et al., 2002). Further, Afrocentricism implies communalism, fluid time orientation, emotional expressiveness, harmony with nature and interdependence (Mbiti, 1999). This observation is particularly important since spirituality is sometimes interchangeably used with religion and or religiosity (Stanard et al., 2000), structures introduced into African spiritual consciousness by the West. To further understand African centered spirituality, Jagers and Smith (1996) explained it thus:

> a belief that all elements of reality contain a certain amount of life force. It entailed believing and behaving as if nonobservable and nonmaterial life forces have governing powers in one's everyday affairs. Thus, a continuous sensitivity to core spiritual qualities takes priority in one's life. Indeed, it goes beyond simple church affiliation. Moreover, it connects a belief in the transcendence of physical death and a sense of continuity with one's ancestors. (p. 430)
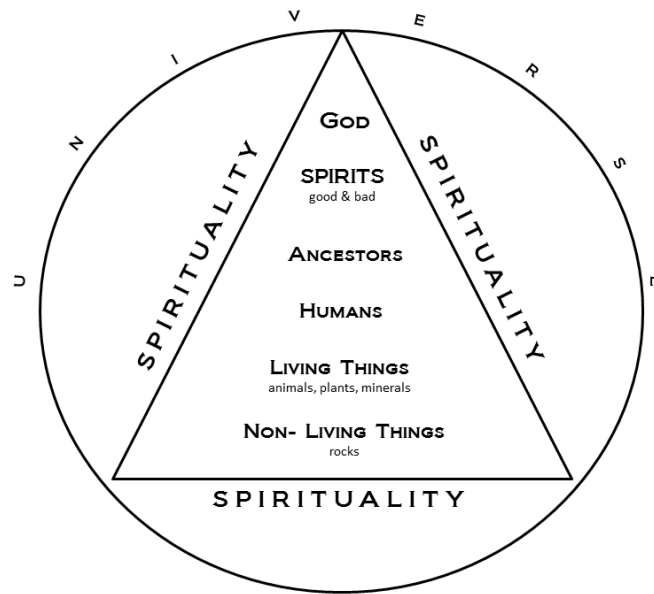
Figure 1. African worldview and spirituality.

Further, Africans believe in the existence of a supreme being that is responsible

for the creation and sustenance of everything. They also believe in spirits being made up

special human beings endowed by the Supreme Being to carry out his wishes. Along

with the special beings are spirits of the dead believed to be ever present in the life of the

living. There is also a belief in spirits within nonhuman elements such as the land,

animals, trees and rivers, nonliving things such as stones, rocks, and caves (Paris, 1995,

Wheeler et al., 2002). Therefore, for the Nigerian American, it is a deep-rooted spiritual

connection with the ancient roots/spirits of a place specifically, that can be summed up as

an unwritten reciprocal relationship between a people and the world of the supernatural.

Spirits of the land varied with each place. People carried these representations as part of

continuity of a group when they migrated from their original places of abode. In other

words, the genealogical descents and rights of the people are linked to their place of

settlement. Settlement implied a belief that the supernatural residents of a place have been contracted through rituals, to protect and advance the course of the people while they in turn adhered to their rules. These rules were given to the people through the elders and priests of the people. They covered but not limited to the claims on resources such as lands for agriculture and farming, family homes and sites for social activities, economic activities and social relations such as marriage, gender roles, social class (caste systems), naming ceremonies, disputes settlement and age group initiations (Koenig, McCullough & Larson, 2001; Mbiti, 1999; Paris, 1995).

The spiritual entities in return protected the people from misfortunes, adjudicated disputes through diviner media. It was common belief that a community could suffer from an individual's misdeeds and vice versa (Bankat, 2001; Idemudia, 2004). Special practitioners had different roles such as healing the ill and countering evil intentions from others; others made charms and amulets for people to wear against bad spirits and or known enemies. These beliefs and practices ensured moral and traditional values within communal life of the people (Essandoh, 1995; Paris, 1995). Nigerians may have difficulty severing their emotional ties to home due to this deep-seated spiritual connection to their land. This may also have several implications for seeking professional psychological help.

The spiritual life of Nigerian people can therefore be discussed from three perspectives. First, the era of complete African traditional spiritual life that had no formal organized body of followers or religion as described above. This period was characterized by the complete trust and belief that life was as destined and the supernatural observed and controlled everything. One's ancestral home was also a

spiritual home; hence, family abode was and still is never vacated. It was generally believed that bad things happening to people including mental illness was a sign of retribution from the gods. This belief and therefore practices such as offering sacrifices were ways to pacify the perceived "just anger" thought to be emitted by the gods. Phenomena such as natural disasters, thunderstorms, famine, infertility, and mental illness were thought to have been caused by individuals' misdeeds and as such merited these occurrences. People were not usually nice to the afflicted individuals since they were thought to have brought the wrath of the gods to the land causing disruption/ punishment in their life.

The second era comprised the presence of Western missionaries, merchants, and government. The indigenes were educated in the three Rs (reading, writing, and arithmetic). The introduction of Christianity and Western education meant that Nigerian natives became exposed to a worldview outside of their horizon. There became the idea of organized religion and religious practices. This period coincided with the scramble and partition of Africa by the European community and the creation of Nigeria as a country. Schools, hospitals, and vocational institutions were established and the indigenes benefitted from Western education and influence. By the third era, Western religion, education, and democracy seemed to have been achieved (Ogbaa, 2003; Okafor, 2009). In this phase, Nigerians were still cautious of the missionaries who worked hard to gain converts to their churches. Indigenous religious practices were still very much vital to the traditional and cultural life of the people.

Many religions exist in Nigeria today because the constitution guarantees religious freedom. There are currently two major religions Christianity and Islam among

other religions as well as indigenous beliefs and practices. It is estimated that there are 50% Muslims and 40% Christians; other beliefs and practices make up the remaining 10% (Ogbaa, 2003). Because Christianity and Islam were introduced into the society by outside influences, there is a geographical divide of where adherents to the different religions dominate. For instance, Christians predominantly live in the south of the country while Muslims live more in the north. The African traditional religion practices are scattered all over. No data were found on the different Christian denominations such as the Methodist, Roman Catholic, Assembly of God, and other denominations that typically ascribed to African traditional values while identifying as Christians. Religious practices in Nigeria follow the cultural and therefore spiritual nuances of the people. These are observed in how Nigerians express their faiths and beliefs in their daily lives including songs, giving thanks with crops and produce from the land, praying for their intentions, the living and the dead. One aspect of the African (Nigerian) culture that is very unique is the pouring of libation at every celebration or ceremony such as marriage, infant naming ceremony, or funeral. These are symbols of communion and fellowship with, and remembrance of the dead. These are the mystical ties that bind the living dead to the surviving relatives (Mbiti, 1999). Anyone who has observed Nigerian Americans during any festivities will agree that they are exuberant, colorful and there is always plenty of food and drinks. Food accompanies every social and cultural events even religious rituals and observations. The major Christian celebrations of Christmas and Easter are national holidays, while the Muslims observe Ramadan, the Islamic month of fasting, and two Eid-El Kabir, marking the end of Hajj season (the time of year when

Muslims make pilgrimage to Mecca), and Eid-El Maulud (birthday of Mohammed)

(Armstrong, 2000).

In the U.S., Ogbaa (2003) noted that wherever there was a congregation of

Nigerian Americans, their basic cultural values of family, respect for the older adults,

festivities involving food, music and dance, marriage, birth and naming ceremonies,

funeral, adjudication between people by elders, hard work, and excellence are seen

regardless of acculturation experiences. He also noted that implicit in those processes is

the fact that Nigerian Americans have had to drop some of these cultural baggage in

order to adapt effectively within the American culture, for instance conforming to the

American family law of monogamy and also valuing every gender child unlike in the

African culture where the male child was more valued. The influences of spirituality on

psychological wellbeing of the Nigerian American cannot be disputed. However, their

beliefs about what causes mental illness and subsequently disposition to seeking

professional psychological help warrant attention from mental healthcare providers.

Mental Illness Conceptualization: An African Perspective

Many researchers have concluded that any assumption or theory cannot be culture

free and so is the sense of self associated with the understanding of illnesses. Swartz

(cited in Ally & Laher, 2008) viewed culture as:

> a set of guidelines (both implicit and explicit) which individuals inherit as
> members of a particular society and which tells them how to view the world, how
> to experience it emotionally, and how to behave in it in relation to other people, to
> supernatural forces or gods, and to the natural environment. (p. 46)

To this end it is necessary to distinguish between the Euro American (Eurocentric) concept of the self from that of the African and thus the Nigerian American since one's self-concept is influenced by the cultural norms, assumptions, tenets, beliefs, and practices within one's culture. It is, therefore, safe to suggest that one's world view about health behaviors and illness as well as treatment pathways and or help seeking cannot be sought to be understood in isolation from the views, predispositions, philosophical assumptions, values, and beliefs held.

The traditional Western perspective conceives self as independent and self-contained (Sue & Sue, 2008). To this end, persons of Eurocentric descent are likely to seek self-defining attributes such as individuation of self, self-actualization and self-efficacy within the context of an individuated self that may not necessarily include family and or community as potential considerations. From this angle, mental health and illness is also viewed as originating from within the individual. There is, therefore, a distinction between the body and "mind"; that is, illness is a measurable pathological condition of the body caused by identifiable physical or chemical events (Henry & Kemp, 2002). One example is the condition of depression that is diagnosed through biological indicators such as measurement of neurotransmitters, changes in brain chemistry (Keller cited in Zondo, 2006). Even this assumption is limited since it does not take into account the subjective nature of such illness or patient's view. This is why a biopsychosocial perspective has gained much importance in mental health care and management in Western cultures since the middle of the 20th century (Sarafino, 1990; Sheridan & Radmacher, 1992).

Within the African context, the concept of self is perceived to be interdependent and embedded within its cultural milieu. Individuals are taught and encouraged to live in such a way that would fit the expectations and norms of socially meaningful others. For this reason, conception of illness including mental illness is thought to be as a result of imbalance or "being out of sync" with the natural order of things. To this end, Ally and Leher (2008) explained that when it comes to mental illness, culture is often equated with religious beliefs and this appears to be the most important determinant of perception of mental illness. When this is articulated within the spirituality context (given the interconnectedness); it is not surprising to see that implicit in the assumption is that nonobservable elements of the individual's life have been violated and therefore need placated for things to be alright again. Idemudia (2004) wrote that illness can even befall a relative for another person's wrong doing. According to Pearce (cited in Idemudia, 2004), this conception may be articulated as defective family interaction that result in psychosocial disturbances in one member of the family (Scapegoat). Idemudia explained that:

> while Western perspective links outcomes to causes via naturalistic or mechanistic models such as Freudian model based on physics; African social models use spiritual/religious idioms of explanation. Both models however view illness as a sign of distress in social relationships in contrast to traditional biomedical model. (p. 13)

To this end, it has been noted that when ill Nigerians tend to be practical in their health seeking behaviors by combining both Western and traditional medicines sometimes in succession (Henry & Kemp, 2002).

Ally and Laher (2008) studied South African Muslim faith healers and identified two distinct variations of illness. The first was mental illness similar to the DSM-IV-TR

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(2004) stipulations (as being manifestation of behavioral, psychological, or biological in the individual) because of mainly behavioral symptoms manifestation such as lack of appetite and sleep. The second, spiritual illness, was believed to be brought about by unseen forces (such as witchcraft, sorcery, or evil spirits) and described as presenting in physical symptoms which were characterized by unexplained aches and pains and in rare circumstance as abnormal behavior. This supported Henry and Kemp's (2002) observations that according to health beliefs and practices of Nigerians living in the U.S., sicknesses are thought to arise in one of two ways; from inanimate, natural forces in the physical environment or as a result of actions of some conscious, malevolent power.

Harkness and Keefer (2000) and Matsumoto (1996) argued that culture is not rooted in biology, race, and nationality but rather a set of attitudes, values, beliefs, and behaviors shared by a group of people. To this end, illness conceptualization by the African people can further be described as a result of distortions or disturbance in the harmony between an individual and the cosmos which may include family, society, peers, ancestors, or a deity (Idemudia, 2004). According to Idemudia (2004), the African way of thinking does not distinguish between the living and nonliving, natural and supernatural, material and immaterial, conscious and unconscious. These sets of phenomena are conceived as opposites in the West but are understood in Africa as unities. The seen and unseen exist in a dynamic interrelationship. Past, present, and future harmoniously weave one into another. The dream world and the daylight world have equal reality. This way of viewing health and disease is similar to the holistic perspective being advanced currently by Western researchers (Idemudia, 2004).

Nefale and Van Dyk (2003) noted that aspects of collectivism and individualism are expressed in every culture at varying degrees ranging from weak to passive to very strong. In Africa, for example, Idemudia (2004) further cautioned that the communalistic culture has started to change because of the dynamic nature of culture. These changes (include but not limited to poverty, wars, migrations) have brought about significant inner conflicts among Africans; hence "stress" has been "viewed as a link between societal or institutional processes and the health of an individual" (Ebigbo, 1989). Indigenous theories of causation of mental health would therefore emphasize good/moral behavior and social harmony in the etiology as well as treatment seeking preferences. For instance Nzewi (cited in Idemudia, 2004) identified five ways of classifying psychosocial disorders:

1. Beneficial reciprocity: when an individual is unable to socialize adequately with his or her neighbors since the need to get along with everyone is a major concern in the interpersonal relationships among the people

2. Degree of shame people experience (i.e., people who are well adjusted experience some degree of shame when their behavior deviated from the norm).

3. Non directional/excessive (i.e., disorientation with time, irregular, bizarre speech and motor behavior).

4. Inappropriate affect (i.e., extreme negative or disruptive emotional states).

5. Poor family relationships (i.e., when an individual is handicapped to the extent that his or her symptoms interfere with fulfilling family responsibilities).

Variations of mental disorders can be also inferred from language descriptive of presenting and observable behaviors/symptoms such as found in Nigerian Ibo language:

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"Onye ala" (mad person), "Isi Mgbaka" (sour head)," Isi Mmebi" (disease head),

"Agwu" (possessed)," Akaliogili" and "Efulefu" (indicating some personality disorders

of different types) and "Ogbanje" (pathologic reincarnation). In fact, a study of

depression and Nigerian born immigrant women in the U.S., a phenomenological study

by Ezeobele et al. (2010) could be described as an embodiment of what has been

discussed so far in this current search. The authors examined a purposive sample of 19

Nigerian born immigrant women's perception of depression and uncovered six themes:

(a) craziness and madness, (b) curse and evil spirit possession, (c) denial and secrecy, (d)

isolation and rejection, (e) spirituality and religion, and (f) need for education. It will,

therefore, be counterintuitive to not articulate that the Nigerian American client will

prefer to use treatment that recognizes his or her way of thinking and value system

(Ezeobele et al 2010; Idemudia, 2004).

Research on Spirituality: Implications for Stigma, Intentions, and Attitudes

Analyses of the data suggest that stigma especially about mental illness is

pervasive and also that meaning and attitudes toward it are derived from within a socio-

cultural context. It is also known that views about what causes mental illness is

associated with stigmatizing attitudes to mental illness (Adewuya & Makanjuola, 2008).

This in turn affects treatment seeking and outcomes (Ally & Laher, 2008; Angermeyer et

al., 2005; Byrne, 2000; Ruane, 2010; Ward & Heidrich, 2009).

In a study of community attitudes toward and knowledge of mental illness in a

South African community, Hugo, Boshoff, Traut, Zungu-Dirwayi, and Stein (2003) used

a questionnaire survey, structured interview, and eight vignettes comprising cases of

mental health scenarios such as schizophrenia, panic disorders, substance abuse, and depression. Six hundred sixty-seven subjects from the general public were asked to watch the cases and then enter their thoughts about what caused the mental health issue they were shown. The researchers reported that cases were conceptualized as stress related or due to lack of willpower rather than as medical disorders. Treatment option was mainly talking over the problem rather than seeking professional medical help. Interestingly, psychotherapy was advocated for substance abuse. They further observed a range in terms of beliefs and causes. For instance, there was a significant difference in the extent to which disorders were considered to be due to stress, a weak character, or a medical disorder. Over 80% (83%) of the respondents attributed causation of panic disorder to stress, 52.3% felt that schizophrenia was due to weak character, and 48% blamed substance abuse. In contrast, schizophrenia (42.5%) and panic disorders (55.1%) were also conceived as medical disorders. When it came to help seeking, several options were noted, including prayer, natural remedies, medical practitioner, and psychotherapy, but 54.6% rated psychotropic medication as probably not or definitely not the best treatment option for the vignette they were presented. This study is particularly relevant to the current research due to inclusion of several possible perceptions of causes of mental illness (biology, environment, beliefs, and disease) indicating the complicated situation that an African client may have in articulating cause, belief, and treatment-seeking behaviors. Although based on an earlier study conducted in Europe, the authors modified the questionnaire and validated it to suit the sample they were working with. Limitations, however, seem to stem from a lack of probability sampling and extrapolation to the general South African public since it was conducted in one area of the country.

Also, the mental illnesses selections were suggestive of extreme mental conditions thus limiting the broad spectrum or range of mental health/illness as being on a continuum. This may be indicative of what and how Africans conceptualize mental health issues and treatment options. Because there were several vignettes, results were also a bit confusing to this current researcher in terms of attitudes and treatment choices. The research design seemed to have led the subjects or at the very least helped confirm the researchers' suspicions.

Similarly, another study of South African subjects by Samouilhan and Seabi (2010) sought to investigate students' beliefs about causes of mental illness given the African beliefs that witchcraft and evil spirits caused mental illness. The sample consisted of 112 students from the faculties of law and engineering of a large South African university. In addition to demographic information, a vignette scale measuring the students' choices of etiology of mental illness and treatment options and Fisher and Farina's Attitudes toward Seeking Professional Psychological Help Scale, shortened version were used. Results showed that participants viewed stressful events as the cause of depression. Substance abuse and chemical imbalance was associated with schizophrenia while negative social factors were identified as causing anorexia nervosa. Professional psychological intervention was most identified as the top treatment by 48% of the participants. Limitations to this study were from the small sample that was not representative of the general public given that these were students in higher education. Further, the questionnaires were not normed and standardized for the South African population and may have introduced cultural bias to the study outcome. Due to the high number of research questions, the authors could not ascertain all the beliefs about causes

and treatment options ratings in depth. They stated that the vignettes did not fully explain the various types of mental illness in depth and this may have confused the participants as well limited their self expression about etiology and treatment beliefs. It further did not ascertain from the subjects whether they had been diagnosed of any mental illnesses or had relatives or friends who were suffering from mental illness. This study did not specifically investigate whether spirituality influenced beliefs about mental illness causation and treatment options as a result.

Adewuya and Makanjuola (2008) researched lay beliefs regarding causes of mental illness in Nigeria, exploring patterns and correlates. This was a cross sectional study involving 2,078 subjects in southwestern Nigeria. This sample comprised respondents from the rural (31.7%), semi-urban (34.3%), and urban (934%) communities. Respondents were asked to fill out a demographic variable questionnaire and also another questionnaire containing perceived causes of mental illness. Options were categorized under psychosocial, supernatural, and biological causal factors. It was noted that in some cases, multiple causations were endorsed in each category. However, beliefs in supernatural factors such as witchcraft/sorcery/evil spirit (65.5%), misuse of psychoactive substances and alcohol (72.35), and God's will/divine punishment (50.1%) were most commonly rated. Personal deficit/failure were least endorsed at 10.2%. The study found that multiple causation endorsement correlated with living in the urban areas, higher education, caring for the mentally ill as well as having a friend or family member with mental illness. Also, endorsing multiple items on supernatural causal factors was significantly associated with age, ethnicity, urbanicity, and having an encounter with the mentally ill. Further, endorsing more than one item on biological causes was associated

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with ethnicity, occupational status, and highest education, caring for the mentally ill, and having a family member or friend with mental illness. These findings were in agreement with previously mentioned studies on Nigerians (Ezeobele et al., 2010; Gureje et al., 2005; Gureje et al., 2005; Kabir et al., 2004). The study participants were administered a demographic questionnaire. It was also ascertained whether each of the member sample had mental health issues or cared for someone who had mental illness or had family or friends who suffered from any type of mental illness. Respondents' attribution of mental illness was assessed by asking the participants to respond to a nine-item questionnaire that investigated possible causes of mental illness. These included psychosocial factors (substance and alcohol misuse, life stresses, personal deficits, or failure/ lack of willpower); supernatural factors (witchcraft, sorcery, evil spirits, God's will and divine punishment and destiny and bad luck); and biological factors (heredity, brain injury, and contact with mentally ill and childbirth). These items were drawn from a list of 23 possible causes of mental illness suggested by relatives, patients, community opinion leaders, traditional healers, spiritual healers, and the lay public. The list was narrowed down by a panel of psychiatrists and representatives from the list. Using a 4-point Likert scale (*not a cause, rarely a cause, likely a cause,* and *definitely a cause*), the respondents were asked to indicate how relevant they considered each potential cause to be. Responses of "likely a cause" and definitely a cause were counted as endorsing a cause. The authors noted that, "although the questionnaire used in this study seemed to have face validity, the psychometric property was not formally examined before use."

Ogunsemi et al. (2008) researched stigmatizing attitude of medical students towards a psychiatric label. Methods included use of questionnaire for demographic

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information, a single paragraph case description illustrating a normal person and a Social

Distance Scale. Questions on expected burden were used to elicit responses from 144

final year medical students who had previous exposure to psychiatric posting. The

subjects were randomly assigned to two groups. Group A received the case study with

psychiatric label attached, while Group B received same case without a label. Each case

description was followed by 16 questions to which the participants were asked to rate on

a 4-point scale ranging from *definitely agree* to *definitely disagree*. The questions from 1

to 13 measured social distance between oneself and the person depicted in the case

scenario while questions 14, 15, and 16 assessed for possible perception of the person in

the case scenario being a burden. The questionnaire and case story were modified

versions from earlier studies by Sari, Arkar, and Alkin (cited in Ogunsemi et al., 2008).

Responses from Group A indicated behavioral distance such as reluctance to rent their

houses to the person labeled as psychiatric ($p = 0.003$), were unwilling to live next door

to the man depicted ($p = 0.004$) or allow their sister to be married to the man ($p = 0.001$).

They also felt that this individual would physically ($p = 0.005$) and emotionally ($p = 0.004$) exhaust them. A limitation to this study comes from the sample constitution,

medically inclined students who may be able to distinguish psychiatric from

nonpsychiatric symptoms thus lending it to author and respondents biases.

Another study by Adewuya and Oguntade (2007) investigated doctors' attitudes

toward people with mental illness in western Nigeria. This study was undertaken with

the premise that knowledge about mental illness was likely to reduce stigma about mental

illness and the likelihood that mental health care would be of benefit to sufferers. The

312 participants were randomly selected from eight health institutions in three states in

southwestern Nigeria. The health institutions consisted of two university teaching

hospitals, two federal medical centers, and four general hospitals. The participants

completed semi-structured demography questionnaire including information on years of

practice, experience of managing a patient with mental illness and having a friend or

family who has or had mental illness. The section on causation was also categorized into

four sections including social, personal, supernatural, and biological and consisted of

several items that were rank ordered. A 4-point Likert scale (*not a cause, rarely a cause,*

likely a cause, and *definitely a cause*) was used to obtain how important they considered

each potential cause to be. Also, respondents' perception of the personal characteristics

of the mentally ill was measured by a list of nine personal attributes generated by factor

analysis. Respondents were asked to indicate on a 4-point Likert scale (*definitely not*

true, probably not true, probably true and *definitely true*) the extent indicated attributes

applied to people with mental illness. The stereotyped components included perceived

dangerousness (dangerous, aggressive, unpredictable, lacking self control, frightened and

strange) and perceived dependency (dependent on others, needy and helpless responses of

probably true and definitely true were counted as signifying attribution. The participants

were further asked to choose one category (complete cure, partial remission, persistence

of the problem, progressive deterioration, or do not know) to indicate possible assessment

prognosis. Social acceptance and social stigmatization was measured by a modified

version of Link's Discrimination-Devaluation Scale that comprises 12 items and 6

statements on perceived social acceptance of psychiatric patients, and another 6

statements on perceived social stigmatization and discrimination of former mental

patients.

Respondents' social distance toward people with mental illness was measured with modified version of the Borgadus Social Distance Scale. The five most endorsed causes of mental illness included abuse of drugs and alcohol (67.9%), personal, financial, or marital stress (58.3%), evil spirits, witches, and sorcery (53.8%), brain injury and infections of the brain and heredity (49.4%). Also, the five noted characteristics of the mentally ill included unpredictability (85.9%), dangerousness (70.5%), are lacking self-control (59%), aggressive (53%), and dependent on others (51%). Further findings from this study also buttressed previous finds such as that behavior toward the mentally ill included isolation and blame by the public. In this instance, the authors found that high social distance correlated with age, sex, and having a close person who suffered with mental illness. For example, older and more experienced physicians were found to be positively disposed to persons with mental illness possibly due to more exposure and contact with the mentally ill. Higher social distance by the female doctors was conceived as fear of aggression/danger from the mentally ill "as traditionally men are expected to be outwardly braver than women are." Limitations lie in the sample being obtained from one area of the country, one group of mental health professionals and also not going beyond the construct of stigma to ascertain attitudes toward the mentally.

The above studies support the commonly held beliefs about people with mental illness such as that they are violent, incapable of taking responsibilities, and of poor appearance; hence, attitude toward them manifest mainly in isolating and or alienation (Corrigan, 2004). Further, it has been documented that these individuals feel ashamed, devalued, suffer from low self esteem and depression (Link & Phelan, 2001; Vogel &

Armstrong, 2010); factors that are likely to discourage psychological help seeking

(Corrigan, 2004; Link & Phelan, 2001; Vogel, Wade, & Ascheman, 2009).

Botha, Koen, and Niehaus (2006) explored a group of subjects in South Africa

suffering from schizophrenia to understand their perception of the public toward them.

The sample consisted of 100 patients, 39 females and 61 males. It also consisted of

English, Afrikaans and Xhosa-speaking subjects with a mean age of 39.85 years. The

Internalized Stigma of Mental Illness Scale (ISMI) was used; however, this was modified

to include six items focusing specifically on investigating the experience of stigma within

the South African context. The authors specifically investigated the presence or absence

of abuse as a form of stigmatization, the effects of perceived stigma on compliance, and

the perceived role of the media in stigmatization. Results showed that more than half of

the sample (58%) had been called names because of their mental illness, while 39%

reported physical abuse. Between and within group comparisons showed that the Xhosa-

speaking group reported physical abuse at a significance level of $p = 0.036$. Results also

showed that males were more likely than females to experience abuse as well as not

comply with treatment. The study further revealed an unwillingness by some participants

to continue treatment (18%) because it reminded them that they were ill, and 16%

reported difficulty attending clinic for treatment for fear of others finding out they were

sick. Patients with multiple admissions reported increased discrimination experiences

including name-calling and verbal and physical abuse. Although less than a third (29%)

of participants agreed that the media had a negative influence on perceptions regarding

mental illness, there was a significant difference between groups. For example, subjects

who spoke other languages besides Afrikaans and those educated beyond primary school

levels expressed media reporting to be negative. A limitation to this design rests in its use of one group of mental health patients and therefore limits extrapolation to the mental health community in general. While this study sought to investigate self stigma and stigma as a form of abuse, it did not go further to articulate the influence of spirituality on public and self-stigmas. It is known that mental illness perception and responses thereof are influenced by culture that is not separate from the spirituality of the African person.

The influence of stigma both by the public and internalized or self-stigma cannot be over emphasized. It is well documented that the process of stigma begins as early as in the family of origin and continues to be reinforced at the macro levels such as in refusing employment, policies that do not equate mental health needs and care and lack of awareness about causes and processes of mental illness (Corrigan, 2008).

It is the contention of the present study that although stigma and intentions were found to affect psychological help seeking in general, studies on African populations in the U.S. have not sufficiently explored these concepts (stigma, attitudes, and intention) in order to actually understand their etiology and as such the strong influence that spirituality has on stigma and attitudes and potentially on intention to seek help from mental health professionals. This contention is founded on the conviction that Afrocentric mentality is pervasive and spiritually deep rooted and therefore compartmentalizing cognition, emotion, and social attributes that accompany mental illness could be counterproductive in its management. For instance, Adewuya and Oguntade (2007) noted that drug use may be viewed as moral failing within this cultural paradigm and as such may be one reason for a negative attitude toward the mentally ill (people may perceive them as lost cause). Moreover, the notion that mental illness is

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based on objective physical knowledge of the brain has long been seriously questioned (Sarafino, 1990; Sheridan & Radmacher, 1992). Further, the understanding that literatures have illumined on the relationship between beliefs about etiology of an illness and subsequent treatment seeking cannot be over emphasized (Anglin, Alberti, Link, & Phelan, 2008; Samouilhan & Seabi, 2010).

Stigma about mental illness can be said to be derived from an Afrocentric worldview and related spirituality when the belief about what causes mental illness is attributed to supernatural forces beyond ones control (Adewuya & Makanjuola, 2008; Ally & Laher, 2008; Samouilhan & Seabi, 2010); and believed in the United States of America (U.S.A) and Canada by people of African descent to be caused by bad character and of natural origin (Anglin et al., 2008; Ward & Heidrich, 2009) and as such would incur attitudes that are unlikely to encourage both the sufferer and significant others or the society at large to want to help situation.

Mental Health Practices of Nigerian Americans

Data surveyed so far indicate that mental illness is caused by several factors including psychosocial, biological/heredity/brain injury, and also supernatural forces. Studies have also shown that mental health patients may be unwilling to seek treatment in formal settings (including medical and psychological) due to fear of being devalued and hurt. To this end, the mental health practices of Africans have been shown to include several options such as spiritual and traditional healers, church pastors, and use of native charms and diviners (Ally & Laher, 2008). Spiritual options would include prayer; for example, the individual who needs help may ask friends and family for prayers.

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Sometimes, family and friends will initiate prayer groups for the person. Also, prayers may be offered on behalf of the individual at the church or other social gatherings. The traditional healer may be a person who is believed to be endowed with supernatural powers and is known to perform healing functions traditionally. It is believed that people would go to such traditional media due to the belief that their fortune may be as a result malevolent spirit. As such, this type of healer may give amulets, charms, and leaves to the family of the sick person. Also, Nigerian Americans are known to combine both traditional and Western medical practices (Henry & Kemp, 2002). In fact, Adewuya and Makanjuola (2009) in assessing preferred treatment for mental illness among southwestern Nigerians noted that in a sample of 2,075, spiritual healers was endorsed by 41% of the respondents, while 30% endorsed traditional healers and 29%, hospitals and western medicine.

It has been established from literature previously cited in the above sections that ethnic minorities in the U.S. underutilize mental healthcare; a search along this line revealed that similar trends have been observed in South Africa where the authors noted that in spite of availability of mental health care, people delayed seeking treatment for up to five years (Samouilhan & Seabi, 2010). These authors sought to investigate students' beliefs about causes of mental illness given the African beliefs that witchcraft and evil spirits caused mental illness and as noted, they found conflicting results ranging from not believing in formal methods of treatment, biology to logistics involving transportation and support systems availability.

As discussed previously, the state of health care and specifically mental health care continue to be in dire distress in African countries in general. Leaders continue to

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fail in their refusal to pass policies that will educate and encourage wholesome affordable

care in general (Abati, 2008). Most researchers believe that this is a result of

combination of factors ranging from a lack of scientific knowledge about what constitutes

mental illness to cultural influences such as belief about what causes mental illness and

conflicts emanating from fusing traditional beliefs with Western orientation. One

observation from the present researcher's perspective is that even though individuals seek

help from sources like pastors and healers, it may not necessarily mean that there is

nonawareness of mental illness as a product of heredity as indicated even in studies

among Nigerians. Further, Henry and Kemp (2002) noted that Nigerians in the U.S.

often combined both formal medical and traditional practices including prayer and use of

charms and or other items sent to them by relatives in Nigeria. This strongly reinforces

the notions that cultural factors and specifically Afrocentric worldviews and spirituality

do influence attitudes and practices related to mental health and health in general.

Need for the Study

The African American, and specifically Nigerian American and other ethnic

minority clients, may be reluctant to seek professional psychological help because their

beliefs about the causes of mental illness and therefore treatment expectations may not be

acknowledged by counselors. Examined literature so far has indicated that even if these

types of clients were to engage in any counseling relationship, they were likely to

terminate prematurely due to several reasons including lack of trust about the counselor's

intentions and understanding of their situation (Schwarzbaum & Jones Thomas, 2008;

Sue & Sue, 2008).

Also, with what is known about the processes and impact of variables such as stigma, beliefs about the etiology and attitudes toward mental illness, the counseling profession has not adequately addressed this in their training curriculum hence, the stipulation by CACREP to incorporate multicultural competence training in counselor education programs in the country. To the extent this will be accomplished rests on what is known about cultures of origin and cultural influences impacting immigrants even here in the U.S. (Hays & Erford, 2010). This is why it is pertinent to look beyond the noted variables to ascertain a more impactful variable such as Afrocentric Spirituality that is at the core of the cultural values of most ethnic Americans such as the Nigerian Americans.

Researchers in this area have constantly called for public education about the effects of stigma on seeking mental health in general and also a change in policies to favor the stigmatized/ persons suffering from mental health issues (Corrigan, 2004). What seems to be lacking in all these endeavors is going beyond what is observable to understanding the origins or roots of why people feel and act the way they do toward stigmatized clients. People will include counselors and other mental health workers because it is only a shift in cognition that can impact stigma about mental health. When this happens, the culture of exclusion both at the micro and macro levels will be impacted. This current research was aimed at illuminating the mental health profession about the influence of spirituality on stigma and inadvertently intentions and mental health help seeking. This is because ethnic cultures tend to live a collectivistic way of life which fuses all aspects of life into one whole essence. They are likely to present to counseling if they are encouraged by significant people in their lives. If not, they may only present in crises or emergency situations as discussed previously. Studies found so

far show that Africans tend to believe that supernatural forces, among other reasons, contribute to causes of mental illness. In the aforementioned literatures, Africans were known to believe that all aspects of a person's life is influenced and controlled by God, the spirits, ancestors, and deities. It is therefore not counterintuitive for the Nigerian American client to consult with a pastor and or traditional healer for mental health needs.

Research methodologies reviewed fell short mostly because the samples were not diverse (Adewuya & Makanjuola, 2008; Botha et al., 2006; Samouilhan & Seabi, 2010). Finally, none of the studies went beyond the scope of attitude, stigma, and etiology to investigate their origins. This current study, therefore, explored the relations among variables such as stigma, intentions, and attitudes towards seeking professional psychological help and spirituality using a spread sample of four U.S. locations where Nigerian Americans reside. A spread sample ensured diversity of perceptions and backgrounds. Inclusion of the spirituality construct added a more in depth comprehension to what is known currently about ethnic Americans. It will assist counselors and mental health workers in addressing these issues when they are faced with clients who may be conflicted about how these beliefs may be impacting their sense of self and attitudes toward seeking mental health help within the United States. Further, the days of conceptualizing psychological issues from a single worldview are over given the multicultural and diverse nature of the U.S. (Sue & Sue, 2008).

Summary

This chapter discussed historical perspectives of Nigerian Americans in addition to the worldview and spirituality of the African people. The chapter further discussed

how mental illness is conceived from an African perspective in addition to mental health

practices of Nigerian Americans. Further discussions included implications of stigma,

attitudes and intentions as they relate to research on Afrocentric Spirituality among

African clients.

CHAPTER III

METHODOLOGY

This chapter details the methods that were used to conduct this study. It includes discussions centered on research design, sample selection, instrumentation, and data collection and analysis. These procedures were used to investigate the relations between the degree of Afrocentric Spirituality and psychological help-seeking attitudes, intentions and stigma among Nigerian Americans.

Research Questions

Research Question 1: Is there a relation between Afrocentric Spirituality and attitudes toward seeking psychological help among Nigerian Americans?

Research Question 2: Is there a relation between Afrocentric Spirituality and intentions to seek psychological help among Nigerian Americans?

Research Question 3: Is there a relation between Afrocentric Spirituality and self or other-perceived stigmas toward psychological help seeking among Nigerian Americans?

Research Hypotheses

Research Hypothesis 1: There will be a significant negative correlation between Afrocentric Spirituality (measured by the Spirituality Scale, Appendix C) and attitude toward seeking psychological help (measured by Attitude Toward Seeking Psychological Help Scale, Appendix G). It was assumed that stronger

Afrocentric spiritual values among Nigerian Americans will correlate with more negative attitudes toward professional psychological help seeking.

Research Hypothesis 2: There will be a significant negative correlation between Afrocentric Spirituality (measured by the Spirituality Scale, Appendix C) and intention to seek professional psychological help (measured by the Intention to Seek Counseling Inventory, Appendix F). It was assumed that stronger Afrocentric spiritual values among Nigerian Americans will correlate with less likelihood to disclose willingness to seek professional psychological help.

Research Hypothesis 3: There will be a significant positive correlation between Afrocentric Spirituality and stigma of counseling among Nigerian Americans. It was assumed that stronger Afrocentric spiritual values among Nigerian Americans will correlate with stronger stigma toward psychological help seeking. Because there are two constructs of stigma, "Self" and "Other" stigma, two sub-hypotheses were generated.

a. There will be a significant positive correlation between Afrocentric Spirituality (measured by the Spirituality Scale; see Appendix C) and other stigma of counseling (measured by the Perception of Stigmatization by Others for Seeking Psychological Help Scale; see Appendix D) among Nigerian Americans.

b. There will be a significant positive correlation between Afrocentric Spirituality (measured by the Spirituality Scale; see Appendix C) and self-stigma of counseling (measured by the Self Stigma of Seeking Help Scale; see Appendix E) among Nigerian Americans.

Participants

Participants were delimited to Nigerian Americans, defined as citizens of the U.S. who are or descend from immigrants from Nigeria. They included first generation immigrants who were not born in the U.S. but immigrated to the U.S. at age 18 years or older. The sample comprised adult Nigerian Americans of both sexes. The sample included participants from different tribes, religions, professions, and languages from Nigeria. Participants were not delimited by sex, marital status, level of education, SES, or income. Nigerians who immigrated under age 18 were not eligible for this study. A

power analysis was calculated to determine a sufficient sample size to detect relationships at a medium effect size ($f^2 = .15$) (Cohen, Cohen, & West, 2003; McNeil, Newman, & Kelly, 1996), using an alpha level of .05, with four predictor variables, and a power of .80. A sample size of approximately 84 was needed.

A total of 122 participants were recruited for the present study. There were 58 (47.5%) males and 64 (52.5%) females who participated. Eighty-three percent were married, 14.2% were single, and 2.5% were partnered with a significant other. The youngest participant was 22 and the oldest was 80, with an average age of approximately 48. The average age at immigration was approximately 29. Almost all the participants were formally educated, as educational levels showed a range from high school to Ph.D. Specifically, about 60% of the participants had a master's degree or a doctorate. Only four (3.3%) participants reported stopping their education at the high school level, and only nine (7.4%) responded as having only earned an associate's degree. The majority of the participants resided in Illinois (23%), Ohio (33.6%), and Texas (33.6%). Regarding religion, the majority were Catholic (59.2%). A significant minority were Protestant (30.5%). Most participants earned $75,000 or above (51.7%), while 26.3% reported earning between $50,001 and $75,000. Only six participants (5.1%) indicated earning less than $25,000. Similarly, the majority of the participants (91.1%) self-identified as middle or high socioeconomic status. Table 1 shows a summary of demographic statistics for the sample population.

Table 1

Summary of Demographic Statistics

Variable	Frequency	Valid percent
Gender (n = 122)		
Male	58.0	47.5
Female	64.0	52.5
Marital Status (n = 120)		
Married	100.0	83.3
Single	17.0	14.2
Partnered	3.0	2.5
Education (n = 122)		
High School	4	3.3
Associate	9.0	7.4
Bachelors	36.0	29.5
Masters	53.0	43.4
PhD	20.0	16.4
State (n = 124)		
California	9.0	7.4
Illinois	28.0	23.0
Maryland	2.0	1.6
Ohio	41.0	33.6
Texas	43.0	33.6
Washington DC	1.0	.8
Religion (n = 120)		
African Trad Religion	1.0	0.8
Buddhist	1.0	0.8
Catholic	71.0	59.2
Episcopal	1.0	0.8
Evangelical	1.0	0.8
Methodist	6.0	5.0
Non-Denominational	2.0	1.7
Presbyterian	1.0	0.8
Protestant	36.0	30.0
Income (n = 118)		
Less than $25,000	6.0	5.1
$25,001 - $50,000	20.0	16.9

Table 1

Summary of Demographic Statistics   (continued)

Variable	Frequency	Valid percent
$50,001 - $75,000	31.0	26.3
$75,001 - $100,000	25.0	21.2
$100,001 +	36.0	30.5
Self-Reported SES (n = 122)		
1 Low	2	1.6
2	0	.0
3	2	1.6
4	7	5.7
5 Middle	34	27.9
6	28	23.0
7	19	15.6
8	21	17.2
9	.0	0
10 Upper	9.0	7.4

Procedures

Participants were recruited after this study had been approved by The University

of Akron's Institutional Review Board. Participants were recruited through researcher

contact with Nigerian organizations in Illinois, Ohio, and Texas. A convenience sample

from each of these states was chosen because they each have a concentration of Nigerian

Americans (e.g., Illinois and Texas) or were in close proximity to where the researcher

resided (e.g., Ohio). The researcher visited the states in person to collect the surveys in

order to ensure increased return rates of the surveys. Also, this type of method lends

itself to the very cultural disposition of the study sample. Prior to travelling to the

different locations, the researcher first obtained contact information (from known

Nigerian Americans who knew the "elder" or "persons" contact) responsible for Nigerian

Americans in each state by phone. This was because Nigerian Americans tended to form semi-formal organizations wherever they are clustered, where they tend to meet and socialize (Ogbaa, 2003; Okafor, 2009). The persons contacted were the presidents or secretaries of the groups. These persons were notified by the researcher in a telephone call of the intention to collect data for the purpose of research.

The contact persons then informed the group members; the groups conferred and agreed on appropriate dates when the researcher could come and collect the data at their meetings. On visiting the location, the researcher explained the study and also informed participants on how to fill out the information packet that contained paper and pencil questionnaires. Data collection packets included: (a) an informed consent script (see Appendix A), (b) a demographic questionnaire (see Appendix B), (c) the Spirituality Scale (see Appendix C), (d) Perception of Stigmatization by Others for Seeking Psychological Help scale (see Appendix D), (e) Self Stigma of Seeking Help scale (see Appendix E), (f) Intention to Seek Counseling Inventory (see Appendix F), and (g) Attitude Toward Seeking Psychological Help Scale- shortened form (see Appendix G).

The instructions on how to fill out the packets were explained to the groups and the researcher was on site to guide participants through the process. The participants were also informed that they could discontinue this activity should they feel uncomfortable. The researcher read the informed consent script (see Appendix A) to the participants and addressed any concerns they had regarding their role in the process before questionnaire completion began. The researcher did not obtain any written or signed informed consent from participants in order to ensure anonymity of participants as well as honesty in response to the research questionnaires. Informed consent was

assumed when the respondents willingly chose to complete the anonymous surveys.

Participants were remunerated for their participation by way of a drawing in which they

could win a gift card to a local restaurant.

Instruments

This investigation utilized one informed consent document (see Appendix A), one

researcher generated demographic questionnaire (see Appendix B) and five instruments:

the Spirituality Scale (see Appendix C), Perception of Stigmatization by Others for

Seeking Psychological Help scale (see Appendix D), Self Stigma of Seeking Help scale

(see Appendix E), Intention to Seek Counseling Inventory (see Appendix F), and Attitude

Toward Seeking Psychological Help Scale - shortened form (see Appendix G). The

instruments measured the following constructs: degrees of Afrocentric Spirituality, self

and other stigma, intentions to seek counseling, and attitudes toward seeking

psychological help.

Informed Consent Script

The researcher read an informed script to the participants prior to filling out the

survey. The purpose of this script was to make participants aware of their own choice to

participate in this study and their rights as research participants. The script included the

title of the research study, information about the researcher, the purpose of the research

study procedures that would be used, risks, and discomforts and benefits of this study. It

also included information related to the right to refuse to participate or withdraw from the

study. It also informed the participants that efforts would be taken to maintain their

privacy and confidentiality particularly with regard to handling the information collected

from the study. It also included contact information of the researcher and her academic

adviser.

Demographic Questionnaire

The demographic questionnaire was included in the survey in order to collect data

about participants' background characteristics. Participants were asked to provide

information such as their age, sex, relationship status, tribe, religion, educational

level/academic status, socioeconomic/salary scale, indication of whether they were

students or professionals, number of years in the U.S., age of immigration to the U.S.,

and whether they were born in the U.S. (an exclusion criterion). In addition, participants

responded to questions assessing their prior history of seeking psychological help for a

personal or emotional problem from a spiritual healer, and finally their preferred

treatment path should they wish to seek help in the future.

Spirituality Scale (SS)

The SS is a 20-item measure developed by Jagers, Boykin, and Smith to assess

spirituality from an African perspective. It contains 25 items, five of which are fillers

and will not be scored. The items are responded to on a 6-point Likert scale ranging from

1 (*completely false*) to 6 (*completely true*). Therefore, the total score for the SS ranges

from 20 to 120. Items 1, 2, 3, 4, 6, 7, 11, 12, 13, 16, 21, 23, and 25 are scored as

responded to and comprise Afrocentric values for example, "To me every object has

some amount of spiritual quality." Items 5, 8, 10, 19, 22, and 25 are fillers that do not

carry spiritual weight and should not be scored. Items 9, 14, 15, 17, 18, and 20 are

reverse keyed /scored. Examples of filler items include sentences like: "I believe more in

politics than religion as a way for people to come together**"** and **"**We all need knowledge

of world religions." One total score is obtained by summing ratings for all questions.

This instrument is brief and easily administered and scored (Stanard et al., 2000).

The conceptual framework for this instrument was from the definition of spirituality as a

worldview or fundamental organizing principle in African culture. This view includes a

> belief that a non observable and non material life force permeates all reality
> and sensitivity to this takes priority in one's life. It is a belief that goes
> beyond church affiliation and includes the transcendence of physical death
> and a sense of continuity with ones ancestors. (Jagers & Smith, 1996, p.
> 430)

Jagers and Smith (1996) studied a sample of 68 African American (41 females

and 27 males) and 75 European American (31 females and 44 males) participants in an

attempt to further examine this instrument. This study yielded an alpha coefficients of

.77 and .83, respectively. Results of a previous study, as reported in Jagers and Smith

(1996), showed Cronbach's alpha coefficients of .87 for the African American sample

and .84 for European American sample. Also, a 3-week test-retest coefficient of .88 was

generated. The authors noted that "preliminary construct validation for the Spirituality

Scale was established through bivariate relationships between spirituality and constructs

such as religious motivation (Batson, 1996), personal agency (Rotter, 1996) and spiritual

wellbeing (Ellison, 1983)" (Jagers & Smith, 1996, p. 436). The SS demonstrated

significant differences between African Americans and European Americans (Jagers &

Smith, 1996). The present study, which is the first of its kind with a subset of African

Americans (i.e., Nigerian Americans), yielded a Cronbach's alpha of .71.

Perception of Stigmatization by Others for Seeking Psychological Help Scale (PSOSH)

The PSOSH was developed by Vogel et al. (2009) to assess individuals' fear that they would be viewed negatively by significant people in their life should they seek professional psychological help. This 5-item, one-dimensional scale was constructed to measure fear of isolation or stigmatization by others and is set on a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*a great deal*). All items are summed to produce a total PSOSH score, with higher scores suggesting greater fear of being stigmatized by significant others should counseling be sought.

The psychometric properties of this scale were determined in phases of studies with different college student sample populations (Vogel et al., 2009). For instance, a diverse sample of 842 college students (1% Native Americans, 14% Asian Americans, 51% Euro Americans, 10% African Americans, 10% Latin Americans, and 8% mixed racial Americans) yielded internal consistency coefficients for the total sample and for each of the ethnic group: total sample (a = .89), African American (a = .90), Asian American (a =.88), Euro American (a = .90), Latin American (a = .90), Native American (a =.89), Mixed Racial American (a = .89) and international students (a = .83). Also, a confirmatory factor analysis supported the one-dimensional structure of this scale. The authors also noted good construct validity in another diverse sample of 506 undergraduate students (Vogel, Wade, & Haake, 2006). The present study yielded a Cronbach's alpha of .93.

Self-Stigma of Seeking Help (SSOSH)

The SSOSH was developed by Vogel et al. (2006) to measure self or personal

stigma associated with seeking psychological help. It is a 10-item instrument set to be

scored on a 5-point Likert type scale. The responses range from 1 (*strongly disagree*) to

5 (*strongly agree*). All items are summed to produce a total SSOSH score. Higher scores

are meant to reflect greater perception of self-stigma for seeking counseling. As

discussed above, in Vogel et al. (2006) the sample comprising 506 undergraduate

students, construct validity for internalized stigma of seeking help was (r = .37, *p* < .001).

Further, in another sample of 144 undergraduate students, (Vogel et al., 2006) the test

retest reliability coefficient obtained over a 3-week period was accepted at (r = .77, *p* <

.001). The present study yielded a Cronbach's alpha of .83.

Intention to Seek Counseling Inventory (ISCI)

The ISCI is a 17-item instrument that measures the likelihood for seeking

professional psychological help and was developed by Cash, Begley, McCown, and

Weise (1975). The instrument lists a number of different problems that college students

were likely to experience which were factor analyzed to produce three subscales:

Psychological and Interpersonal Concerns (10 items, a = .90), Academic Problems (4

items, a = .71), and Drug and Alcohol Problems (2 items, a = .86, subsequently added by

Cepeda-Benito & Short, 1998). The items are responded to on a 6-point Likert scale

ranging from 1 (*very unlikely*) to 6 (*very likely*). Each subscale is summed for a total

ISCI score. Higher scores suggest that the participants were likely to seek counseling in

the future.

In a study of 235 college students (53% men and 47% women) and a self-reported ethnic sample of 77% Caucasians, 12% Asian and Pacific Islander, 4% African American, 2% Hispanic, 2% native American, and 3% other, Vogel and Armstrong (2010) used psychological and interpersonal concerns and the academic concerns subscales to examine the relationship between self concealment and willingness to seek counseling. They noted an internal consistency of .86 for the psychological and interpersonal concerns subscales and .70 for the academic concerns subscales. These authors stated that their results correlated to the findings on the ISCI by Kelly and Achter (1995) who reported significant positive correlations with help seeking attitudes (r =.36). For this present study, the Cronbach's alpha was 0.96 suggesting a high internal consistency and reliability for this sample population.

Attitudes Toward Seeking Professional Psychological Help Scale- Short Form (ATSPPH-SF)

The ATSPPH was originally a 29-item instrument designed to assess general attitudes toward seeking professional help for psychological problems. This instrument was developed by Fischer and Turner (1970) to clarify the assumption that there were specific attitudes and personality domains that might indicate core attitudes related to seeking help. The scale had four subscales that measured four factors such as recognition of personal need for psychological help, stigma tolerance associated with psychological help, interpersonal openness, and confidence in mental health professionals. This scale showed strong reliability (Good & Wood, 1995) and validity (Al-Darmaki, 2003; So, Gilbert & Romero, 2005).

For the current study, the abbreviated or shortened version was utilized, hence the ATSPPH-SF. This scale was developed by Fischer and Farina (1995) and is a 10-item response instrument scored using a 4-point Likert scale ranging from 0 (*disagree*) to 3 (*agree*). The authors used factor analysis to retain 10 items representing essentially the same constructs as the original 29 items. This instrument specifically measures "core attitudes" toward seeking help and all scores from the 10 items are added to calculate the total score. Similarly, higher scores reflect positive attitudes toward seeking professional help. The authors reported significant correlations with the original measure and a 4-week retest reliability of (r = .80) in a sample of college students (Fischer & Farina, 1995).

It has also demonstrated internal consistency ranging from .82 to .84 (Wallace & Constantine, 2005; Komiya, Good, & Sherrod, 2000). This instrument is known to be the most widely used among different populations such as college students, community residents, and the general population (Elhai, Schweinle & Anderson, 2004) as well as the most commonly used for studies among ethnic minority populations (Yeh, cited in Okafor, 2009). Hackler, Vogel, and Wade (2010) studied attitudes toward seeking professional help for an eating disorder among college students with disordered eating attitudes and behaviors. Of the 145 participants, 88.1% were European American, 5.6% African American, 2.8% Multiracial American, 1.4% Asian American, 1.4% Native American, and 0.7% international students. The sample was predominantly female. The coefficient alpha for the ATSPPH-SF in this sample was .85, indicating a significant positive correlation between help-seeking attitudes and self-stigma and anticipated risks.

In another study, Kim and Omizo (2003) examined Asian cultural values, attitudes toward seeking professional psychological help and willingness to see a counselor; a positive correlation (r = .73) was established. The sample consisted of 242 adult Asian Americans who were recruited from two large institutions in the U.S. The sample comprised 28.1% Chinese, 25.6% Koreans, 13.2% Filipinos, 11.6% Japanese, 11.2% Asian Indians, 3.7% Vietnamese, 2.5% Multiethnic Asians, and 3.7% other. There were 80 first generation participants whose length of stay in the U.S ranged from 0 to 22 years, 110 second generation participants, and 19 fourth generation participants. Palmer (2009) examined the reliability and validity of the ATSPPH- SF using a sample of 94 adult Jamaican Americans and reported a Cronbach's alpha reliability coefficient of .87. Further, Elhai et al. (2008) investigated the reliability and validity of the ATSPPH-SF using two separate samples 296 college students and 389 primary care patients. The college sample was comprised of 67.0% (201) females and 32.7% (98) males, while the medical population consisted of 70.9% (2800) females and 28.1 (111) males. Their ages ranged from 18 to 42 for the college sample and 18 to 90 for the medical group. The researchers reported that the ATSPPH-SF evidenced coefficient alphas of 0 .77 for the college sample 0.78 for the medical patients sample. Among the students, the ATSPPH-SF total score was related to older age (r = 0.23, $p < 0.001$, same with the medical population) and more years of schooling (r = 0.12, $p = < 0.05$ and r = 0.14, $p < 0.01$ for the patients). Significantly higher ATSPPH-SF scores were evident for women (m = 17.77, S.D. = 5.05) than men (m = 15.90, S.D. = 5.44) in the college sample. The present study demonstrated an internal consistency reliability of .71.

Table 2 shows a summary of internal consistency reliability for all instruments used in the present study.

Table 2

Internal Consistency Reliability Results

Scale	Cronbach's Alpha	N of items
Spirituality Scale	.71	25
Other Stigma Scale	.93	5
Self-Stigma Scale	.83	10
Intentions Scale	.92	17
Attitudes Scale	.71	10

Research Design and Data Analyses

This study used a correlational and prediction design. Predictive design is a form of correlational research that uses calculated information about relationships between variables to forecast future outcomes (Sheperis, Young, & Daniels, 2009). In this instance, this current study estimated the likelihood of a particular outcome (stated in the research hypotheses above) by using specific dependent and independent variables. Having observed a relationship, a prediction design was used to decipher the impact of the criterion variable (spirituality) on the predictor variables (stigma, attitudes, and intentions) on seeking professional psychological help. The inferential statistics included correlations and predictions analyses which were used to test the general and specific research hypotheses.

Pearson correlations were chosen to test the first order relationships between the key variable (spirituality) and the other variables (stigma, attitudes, and intentions)

because all variables were continuous. This technique was the most appropriate since the researcher was interested in assessing the strength and directionality of this first order relation (Mertler & Vannatta, 2005). Researcher was interested in knowing the strength of relationship among the variables tested. With this it was expected that regression models related to the research questions could be generated (Mertler & Vannatta, 2005). Therefore, a Pearson correlation matrix was generated to determine the relation between spirituality and help-seeking attitudes, intentions, other stigma, and self-stigma. Each of the three directional research hypotheses was tested according to whether or not statistically significant Pearson correlations were found. Next, all predictor variables shown to have a statistically significant bivariate relation with spirituality were entered into one standard multiple regression analysis. This follow-up analysis was used to determine a prediction model related to the independent variables used in the present study (i.e., and help-seeking attitudes, intentions, other stigma, and self-stigma).

Summary

Details regarding the methodology and research design of this study were presented in this chapter. There is almost no previous research in the area of spirituality as a predictor of intent to seek professional psychological help. Therefore, the focus of this correlational and predictive research design was to investigate and validate the impact of Afrocentric Spirituality on seeking psychological help among Nigerian Americans. This research was conducted by collecting multiple measurements of attitudes, self and other stigmas, and intentions to seek professional psychological help. Correlations and a standard multiple linear regression model were used to test the

research hypotheses and to determine whether consideration of Afrocentric Spirituality

was an important factor when assessing the likelihood of an individual to seek counseling

in the future and also how this construct may continue to impact the attitudes of Nigerian

Americans toward seeking formal psychological help.

CHAPTER IV

RESULTS

This study investigated the relations between the degree of Afrocentric Spirituality and psychological help-seeking attitudes, intentions, and stigma among Nigerian Americans. It employed a correlation and predictive design for data analyses. First, descriptive statistics for the dependent and independent variables are presented. Table 3 shows a summary of these results. Next, Pearson correlations were used to examine relationships between the criterion variable (spirituality) and predictor variables (attitudes, intentions, and self, and other stigmas). Then, a multiple regression analysis was used where significant bivariate relations were found, in order to determine the degree of relationship between attitudes, intentions and self, and other stigma on self-reported level of Afrocentric Spirituality among Nigerian Americans. Finally, exploratory data analyses were conducted in order to follow up on possible trends related to multiple regression analyses results because Afrocentric Spirituality was statistically significantly positively related to help-seeking intentions.

<center>**Descriptive Statistics**</center>

This section presents the results of the descriptive statistics.

Spirituality

All the participants seemed to indicate a belief in Afrocentric values and worldview. The mean score for all items was (M = 92.70, SD = 11.90). The range of scores was 53 to 120, out of a possible range of 20 to 120 for the instrument. This result is higher than the mean SS score of 82.60 reported by Jagers and Smith (1996) for an African American sample. This outcome showed that the sample studied strongly believes in an Afrocentric spiritual worldview, a spiritual affirmation of forces beyond the control of an individual person.

Help-Seeking Attitudes

According to the ATSPPH-SF, a score of 0-10 indicated attitudes toward seeking professional psychological help. Scores in the 11-16 range were indicative of average attitudes, while scores ranging from 17-30 indicated positive attitude toward seeking mental health help. The mean score obtained in the present study ($M = 17.22$, $SD = 5.27$) indicated somewhat positive attitudes toward seeking professional psychological help. This average score is similar to those reported in other studies (e.g., Berger et al., 2005; Hatchett, 2007).

Help-Seeking Intentions

In the present sample population 20% of the participants indicated having sought professional help in the past. Of this proportion the majority (64%) indicated having

gone to a clergy (e.g., a minister or spiritual advisor). Only 5.9% responded that they would seek help from a mental health professional; however, 19.5% reported that they would seek help from a medical doctor, and 0.8% from a traditional African healer. Overall, it appears that the future intention to seek help from a mental health professional was high ($M = 45.26$, $SD = 15.90$). In general, the items that were rated lower may not have been perceived as serious enough for this study population given their demographic and cultural orientation.

Self-Stigma

Although the participants reported moderate levels of self-stigma related to seeking psychological help, ($M = 25.51$, $SD = 7.45$), these levels are lower than self-stigmas reported in other studies of college students by Vogel, Wade, and Haake (2006) and Vogel, Wade, and Hackler (2007). The obtained scores ranged from 11 to 25 indicating that participants did not endorse the upper most levels of the scale (a ceiling of 50).

Other Stigma

The mean score ($M = 12.56$, $SD = 5.66$) also indicated a moderate outcome relating others perception of stigma toward seeking mental health help. In this instance, the range of scores answered indicated a closer proximity to the uppermost score in the scale; a minimum of 5 and a maximum of 25 with a ceiling of 30. This reflected that what others thought about seeking psychological help does impact whether one sought help in the first place.

Table 3

Summary of Descriptive Statistics

	N	Minimum	Maximum	Mean	Standard deviation
Spirituality	117	53	120	92.62	11.89
Other Stigma	121	5	25	12.56	5.66
Self-Stigma	121	11	50	25.51	7.45
Intentions	120	16	96	45.26	15.90
Attitudes	120	4	30	17.22	5.27

Inferential Statistics

This section reviews the statistical results and presents the findings for the research hypotheses. The three research hypotheses are reported individually. In this regard the three research hypotheses posed there was a statistically significant correlation between spirituality and other stigma ($r = .32, p < .001$), and spirituality and help-seeking intentions ($r = .24, p < .05$). Table 4 shows a summary of Pearson correlations for all variables.

Table 4

Pearson Correlation Matrix for Dependent and Independent Variables

	Spirituality	Other Stigma	Self-Stigma	Intentions	Attitudes
Spirituality	1				
Other Stigma	.32**	1			
Self-Stigma	.01	.32**	1		
Intentions	.24*	-.02	-.13	1	
Attitudes	.02	-.25**	-.40**	.35**	1

* $p < 0.05$, ** $p < 0.01$

Research Hypothesis 1: There will be a significant negative correlation between Afrocentric Spirituality and attitude toward seeking psychological help.

Results showed that this directional hypothesis was not supported by research findings. Afrocentric Spirituality was not statistically significantly related to help-seeking attitudes.

Research Hypothesis 2: There will be a significant negative correlation between Afrocentric Spirituality and intention to seek professional psychological help.

Results showed that this directional hypothesis was not supported by research findings. Contrary to expectations, Afrocentric Spirituality was statistically significantly positively related to help-seeking intentions.

Research Hypothesis 3: There will be a significant positive correlation between Afrocentric Spirituality and stigma of counseling among Nigerian Americans.

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3a: There will be a significant positive correlation between Afrocentric Spirituality and other stigma of counseling among Nigerian Americans.

This directional hypothesis was supported by research findings. In the present study Afrocentric Spirituality was statistically significantly positively associated with other stigma, in that perceptions of other stigma for seeking psychological help increased as Afrocentric Spirituality increased.

3b: There will be a significant positive correlation between Afrocentric Spirituality and self-stigma of counseling among Nigerian Americans.

Results showed that this directional hypothesis was not supported by research findings. Afrocentric Spirituality was not statistically significantly related to self-stigma.

Because help-seeking intentions and other stigma were correlated with spirituality, these two variables were included in a standard multiple regression model. Multicollinearity was first tested by obtaining tolerance values for the independent variable (spirituality) and other variables (others stigma and intentions). Tolerance or measure of collinearity was obtained at .99 and therefore there was no problem of multicollinearity (Mertler & Vannatta, 2002). Therefore, the researcher proceded with multiple regression analyses. Standard multiple regression was conducted to determine the accuracy of Afrocentric Spirituality predicting "Other stigma and intentions" to seeking counseling. Regression results indicate that the overall model has a significant value of $R^2 = .16$, $R^2_{adj} = .15$, F $(2,113) = 10.90$, $p > .001$. This model accounted for 16.2% of the variance in spirituality. A summary of regression coefficient is presented in Table 5 and indicated that two independent variables significantly contributed to the model.

Table 5

Coefficients for Model Variables

	B	*β*	*t*	*p*	Bivariate *r*	Partial *r*
Other Stigma	.69	.33	3.79	<.001	.32	.34
Intentions	.18	.25	2.89	<.01	.24	.26

Due to one result that was inconsistent with the directional hypothesis proposed for the present study (spirituality being positively correlated with help-seeking intentions), follow-up exploratory analyses were conducted in order to examine possible influences or mediators for this counterintuitive outcome. First, Pearson correlations were conducted to explore potential relations between Afrocentric Spirituality and age at immigration to the U.S., education level, income, or self-reported SES. Results shown in Table 6 reveal no statistically significant correlations between spirituality and any of these demographic variables.

Table 6

Pearson Correlation Matrix for Spirituality and Demographic Variables

	Age immigrated	Education	Income	SES
Spirituality	-.05	-.07	-.14	.02
P-Value	.60	.48	.15	.81

Next, Pearson correlations were conducted to explore potential relations between help seeking intentions and age at immigration to the U.S., education level, income, or self-reported SES. Results showed only help-seeking intentions and age at immigration to the U.S. were statistically significantly correlated. As shown in Table 7, no other demographic variables were correlated with help-seeking intentions.

Table 7

Pearson Correlation Matrix for Intentions and Demographic Variables

	Age immigrated	Education	Income	SES
Intentions	.21	-.12	-.14	-.01
P-Value	.03*	.18	.12	.94

* $p < .05$

Summary of Results

There were three specific research hypotheses in this study. Each was tested with Pearson's correlations to first ascertain whether there were significant relations with spirituality, and where found, whether those variables predicted degree of spirituality using a standard multiple regression analysis. There were no significant relations found between Afrocentric Spirituality and help-seeking attitudes, nor between Afrocentric Spirituality and self-stigma. However, significant relations were found between Afrocentric Spirituality and other stigma and between Afrocentric Spirituality and help-seeking intentions. Therefore these two variables were entered into a standard linear

multiple regression analysis. The outcome showed that the model was statistically

significant, in that Afrocentric Spirituality was related to a model including other stigma

and help-seeking intentions. Afrocentric Spirituality was unexpectedly positively

correlated with help-seeking intentions, and Afrocentric Spirituality was expectedly

positively correlated with other stigma. Exploratory follow-up analyses correlating

demographic characteristics of the sample with Afrocentric Spirituality and help-seeking

intentions (to better understand the counterintuitive result) showed that there was a

significant positive correlation between age of immigration to the U.S. and help-seeking

intentions. No other demographic characteristics tested significantly correlated with the

variables of interest. Table 8 shows a summary of results for research hypotheses

proposed in the present study.

Table 8

Summary of Results for Research Hypotheses

Hypothesis #	Hypothesis	Statistically Significant	Hypothesis Rejected
1	Afrocentric Spirituality and help seeking attitudes.	No	No
2	Afrocentric Spirituality and help seeking intentions.	Yes	No
3a	Afrocentric Spirituality and other stigma	Yes	Yes
3b	Afrocentric Spirituality and self-stigma	No	No

CHAPTER V

DISCUSSION

The purpose of this study was to investigate the influence of Afrocentric Spirituality on psychological help-seeking attitudes, intentions, and self and other stigma among Nigerian Americans. It has been established that variables such as stigma, attitude and intentions influence psychological help seeking (Komiya & Eells, 2001; Knipscheer & Kleber, 2001, Nadeem et al., 2008). What appeared to be almost missing from research is the driving factor behind the relative variables outcomes. It was, therefore, predicted that African-centered spirituality may influence decisions around seeking psychological help. This may be so because African-centered spirituality is intertwined with its values. There is interconnectedness with all aspects of African life that must not be viewed as separate entities or compartments due to the belief that the governing force influences all aspects of life (Lee, 2012; Mbiti, 1999; Olumbe, 2008; Wheeler, 2004). The assertion, therefore, was that Afrocentric Spirituality may correlate with the aforementioned variables (attitude, intentions, and stigma). For this reason, it was expected that the more a person adhered to Afrocentric Spirituality, the more likely he or she may hold a negative attitude toward seeking mental health care, higher stigma of counseling, and therefore less intention to seek mental health help.

Research Hypothesis 1: There will be a significant negative correlation between Afrocentric Spirituality and attitude toward seeking psychological help.

It was assumed that stronger Afrocentric spiritual values among Nigerian Americans will correlate with more negative attitudes toward professional psychological help. Contrary to expectations this study showed that both variables were not significantly negatively correlated. In other words, holding Afrocentric values did not negate psychological help seeking within this study population. Spirituality did not influence attitude toward seeking counseling as predicted.

Explanation for this result's outcome may lie in the belief about what causes mental illness. The review of literature indicated that Africans including Nigerian Americans were more likely to believe that mental illness was caused by supernatural factors (Adewuya & Makanjuola, 2008; Ally & Laher, 2008; Ezeobele et al., 2010; Kabir et al., 2004). The participants in some of these studies also identified use of psychoactive substances and alcohol, stress, and biology as culprits. The samples were diverse across the board including college level professionals, university students, and the rural populace (Samouilhan & Seabi, 2010). Outcome from the current study sample, therefore, could be articulated as representative of the complex nature of mental illness etiology as well as sociocultural influences on this condition thus making Afrocentric belief one of many factors.

Attitude toward mental health treatment is also another way to further explain this hypothesis outcome. In studies by Adewuya and Makanjuola (2009) and Ally and Laher (2008) on preferred methods of treatment for mental illness, alternative methods such as spiritual and or other means that reflected belief in the causes of mental health issues were reported in both samples. These findings supported Henry and Kemp's (2004) observations of the health practices of Nigerians in the United States. They reported a

plethora of treatments that included formal medical methods in addition to "charms and amulets" that were sent by families of Nigerian Americans from home. These researchers viewed this as a reflection of the practical nature of the Nigerian American individual.

Idemudia's (2004) explanation from social and cultural perspectives may further shed some light in understanding the result's outcome. He contended that Nigerians may actually be articulating psychological problems from a combination of Afrocentric and Eurocentric lenses. Idemudia maintained that the influence of Western culture on African culture cannot be underestimated. Culture as a construct is not static; therefore, Afrocentric Spirituality and values may have been accommodating of the dynamic nature of culture albeit Western within the African milieu and specifically Nigerian. Culture is perceived to be practical and evolutionary in nature rather than static so it is possible that Nigerian Americans may be comfortable with viewing mental illness from also a sociological lens (Idemudia, 2004). This is probably why Nigerian Americans were observed to be likely to use multiple health intervention options that included traditional means (Henry & Kemp, 2004). Therefore, attitude toward seeking mental health help cannot be solely influenced by Afrocentric values alone.

Also, it was indicated in the literature review in chapter II that there were three eras of spirituality evolution in Nigeria. The first was very traditional and possibly had little to no influence from the outside world; hence, Afrocentric Spirituality and values were strong influences and with no scientific advancement or technology likely to see the world otherwise. The second and third eras, however, discussed the influence of Western Christianity/culture and the eventual integration of other religious and cultural values in

the country. Africa and specifically Nigeria could be described as a juxtaposition of cultures. It is, therefore, safe to state that this makes the Nigerian American more likely to be adaptable and/or open to integrating influences other than the typical Afrocentric values. This then supposes that adhering to Afrocentric values may not be a process occurring in a vacuum (Idemudia, 2004).

Further, Diunital thinking or cognition may be another way to articulate this outcome. This is an African way of perception and perceiving life experiences. In Diunital thinking experiences are processed in their fullness as being independent and equal. Different does not mean unequal or bad. African cognition sees "both and" and does not usually adhere to a dichotomous way of perceiving the world. This style of perception may serve to complement "other" cultural views rather than reject or pathologize them. For this reason the Nigerian American's attitude toward seeking help may not be dictated by one way of etiology or cause.

Acculturation within the American culture by this sample population may also explain this outcome. It has been suggested that highly acculturated individuals express more positive attitudes related to the use of mental health services than do less acculturated individuals (Gupta, Kumar, & Stewart, 2002; Ramos-Sanchez & Atkinson, 2009). Suarez (1994) reported a correlation between level of acculturation and use of pap test and mammogram screening among Mexican American women. In this study, the level of acculturation positively influenced use of pap tests and mammograms. Length of residency was an important factor in this study. Similar outcome was also reported by Anderson, Wood, and Sherbourne (1997). Given that the mean age of the study's participants was 48 (SD = 11.14) while mean age of immigration was 29 (SD = 9.29),

this suggests a total of 19 years of residency within the United States. It may be safe to hypothesize that this study population, therefore, have attained some level of acculturation within the American culture. Ogbaa (2003) explained that for the Nigerian American it was necessary for survival and success.

Level of education can partially account for this result's outcome too. The average educational level for this sample was college mostly masters and doctoral levels at 60% of the study sample. It has been documented that acculturation level correlates with level of education (Gupta, Kumar, & Stewart, 2002) and therefore may go to suggest the significant correlation between attitude and Afrocentric Spirituality, irrespective of the expected outcome. Finally, the outcome of this study may be a result of how the questions were phrased rather than that Afrocentric Spirituality did not influence attitude toward seeking counseling.

Research Hypothesis 2: There will be a significant negative correlation between Afrocentric Spirituality and intention to seek professional psychological help.

It was assumed that stronger Afrocentric spiritual values among Nigerian Americans will correlate with less likelihood to disclose willingness to seek professional psychological help. The current study shows that there was a significant positive correlation between intention to seek counseling and Afrocentric Spirituality. This means that being African centered did not negatively impact intention to seek counseling. This outcome is contrary to the findings by Wallace and Constantine (2005) who found that people who espoused Afrocentric values were not likely to consider seeking psychological help. Bagley (2002) even found that intention to seek counseling did not come up even in crises situations for the African American sampled population.

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Goddard (2002) and Magee-Gullate (2010) had a different outcome. In their studies of American college students it was found that individuals were more likely to seek help if significant people suggested it. Although there was no specific study found on the Nigerian American population with regard to intentions to seek psychological help, one unrelated study on gender differences in seeking treatment for sexually transmitted diseases suggested that economic status was positively associated with seeking treatment from a formal source rather than an informal or alternative source. The authors found that those who had college degrees or higher were more likely to seek formal help than those who were not. Also that living in the metropolis compared to rural setting was found to be indicative of seeking formal help (Mmari, Oseni, & Fatusi, 2010). Ujah (2000), on the other hand, argued that expression of intention did not equate use or eventual actions toward the intended act.

Although the hypothesis outcome was not expected, the above studies seem to suggest that if predictions were reliable factors such as gender, demography, educational level, and acculturation may be significant influences on intention to seek counseling among Nigerian Americans (Mmari, Oseni, & Fatusi, 2010; Ujah, 2000). These authors found that higher economic status and education level were positively associated with seeking treatment from a formal source rather than an informal source among Nigerians Americans; a thought that is in line with this result's outcome given the level of education and socio economic status of the study participants. Research has shown that decision to seek help is complex and as such not made in a vacuum. For one, previous experience may encourage or negate future help seeking intentions (Deane, Stogstad, & Williams, 1999) as is the influence of significant people in one's life (Goddard, 2002).

A closer examination of responses from this study's demographic information showed that when the items were broken down, it was found that even though there were positive intentions to seek counseling, the choices indicated that Nigerian Americans were more likely to consult the clergy or the medical doctor before mental health counseling. In fact, while 64% of the study sample would consult a clergy first, only 5% indicated that they had or would consult a mental health professional for help. This suggests that Nigerian Americans may be willing to seek counseling but not initially from the mental health professional. This outcome is also in line with findings by Alvidrez (1999) and Thomas (2009) that Africans and other ethnic groups besides Euro Americans tend to present to the physician's office even for psychological problems. However, the importance and influence of family in the life of the individual cannot be underestimated as family plays a pivotal role in deciding treatment options especially during crises (Okafor, 2009; Thomas, 2009).

Another explanation for this outcome may further lie in the survey instrument, the ISCI. For example, of all the 17 problems listed (weight, conflict with parents, relationship, depression, speech anxiety, choosing a major, dating difficulty, and so on), all but one were rated as "Somewhat Unlikely." The only item that was indicated as serious enough to warrant consideration for professional mental health was "Drug Problem" which showed the highest mean rate on the scale (4.39) indicating an understanding of perhaps the psychological and physiological implications of this condition.

Further, this study was conducted with first generation Nigerian Americans who may still harbor some attitude toward the mental health system from their country of

origin. It is well known that mental health service in Nigeria does not emphasize

professional counseling. Instead, psychiatry which takes care of extreme mental health

issues is commonly acceptable while "regular" counseling issues such as lifespan

developmental issues are left to the family and community. The culture is such that the

people may already be predisposed to solving such issues through alternative means such

as the clergy and or family. The status of what is known as professional counseling in

Nigeria is efficiently carried out within the educational institutions (Okocha & Alika,

2012) and not on other aspects of sociopersonal development.

> Research Hypothesis 3a: There will be a significant positive correlation between
> Afrocentric Spirituality and self and other stigma of counseling among Nigerian
> Americans.

It was assumed that stronger Afrocentric spiritual values among Nigerian

Americans will correlate with stronger stigma toward psychological help seeking.

Because there were two constructs of stigma, **"Self"** and **"Other"** stigma, two sub-

hypotheses were generated.

First, there will be a significant positive correlation between Afrocentric

Spirituality and other stigma of counseling among Nigerian Americans. This hypothesis

was confirmed. If this had gone in the opposite direction, it would have been counter to

the way that mental health problems have been conceived among this sample population

and hence its implications for counseling in general. Wallace and Constantine (2005)

found that in the African American student population, those who showed a higher

degree of Afrocentric values were associated with greater perceived stigma of counseling.

This study's significant positive correlation is in line with the African worldview

and belief system that is interwoven with every aspect of the African life (Mbiti, 1999;

Wheeler, 2002). Similar results were also found among other ethnic groups: Asian, Hispanic and Latina Americans (Nadeem et al., 2008) and Asian Americans (Kim & Omizo, 2003). The researchers reported that Asian Americans would refrain from seeking psychological help due to the belief that they would be viewed as weak. Vogel, Wade, and Ascheman (2009) noted that college students in their study were likely to avoid being identified with any kind of stigma for fear of a negative perception.

The conception that a break from the interconnectedness signifies separation from the whole cannot be underestimated given the belief that the universe works together in order to not only maintain connection but to remain stable or balanced. A split from this "interwovenness" is in itself not a good sign of health or unity of health (Zondo, 2006).

The Afrocentric culture is collectivistic in nature and as such no individual will like to break from the community or bring shame or dishonor to the community to which one belongs. The good and/or progress of the group are placed higher than that of the individual person. So, the "other" stigma outcome can be surmised to reinforce the cultural and social emphasis on the community rather than the individual. The whole society suffers because of one person's misdeed. The mindset, therefore, is that "the stigmatized" is not wanted. It is safe to state that Afrocentric Spirituality could be part of what engenders stigma of mental health in people regardless of socio economic or education levels. Mental illness is perceived to be caused by a combination of factors including the supernatural (Gureje et al., 2005; Kabir et al., 2004; Ogunsemi et al., 2008; Samouilhan & Seabi, 2010). In general Nigerian American people may not want to associate with persons suffering from mental health issues due to perceptions of its origins.

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Stigma invokes fear and as such the stigmatized is ostracized socially and therefore, the mentally ill are avoided and treated unfairly in most societies. The social structure of every society appears so (Carrigan, 2004; Gary, 2002; Ogunsemi et al., 2008). Such attitude toward the mentally ill is not likely to encourage a positive attitude toward counseling in those who need it and their care givers or family members. In one previously discussed study of pregnant Nigerian women living in a New York area who were likely to be affected by HIV, a significant proportion of them refused testing for fear of being identified (Okonkwo et al., 2007).

This result outcome is very important to the counselor, counselor trainee, and counselor educator for two reasons. First, almost no study has been able to link spirituality to stigma of counseling. But by linking this outcome to a Nigerian American client's disposition to counseling, attrition rates for counseling may be reduced within this population. Secondly, the stigmas of counseling and resultant effects have mostly been articulated from a social perspective, for example, poverty, appearance, mental illness, and so on (Carrigan, 2004). This study went beyond these physical reasons to investigate root causation which according to this outcome, stigma appears to be rooted much stronger in Afrocentric Spirituality and values.

Surprisingly, research hypothesis 3b (There will be a significant positive correlation between Afrocentric Spirituality and self-stigma of counseling among Nigerian Americans) yielded a negative outcome. There was not a significant positive correlation between self-stigma and Afrocentric Spirituality. It is not clear how to articulate this outcome; however, a comparable close study showed that self-stigma may be one reason people with mental health issues do not present to counseling. Botha,

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Koen, and Niehaus (2006) sampled a group of subjects in South Africa who were suffering from schizophrenia. They wanted to understand their perception of the public toward them. The authors specifically investigated the presence or absence of abuse as a form of stigmatization, the effects of perceived stigma on treatment compliance, and perceived role of stigma. This study used a modified ISMI scale which included six items focusing specifically on the experience of stigma within the South African context. Results showed that the participants reported having been called names in addition to having experienced physical abuse. The study further revealed that the participants reported an unwillingness to continue treatment while some reported difficulty attending the clinic for treatment for fear of others finding out they were sick.

It is known that stigma causes low self-esteem, a condition that of itself can induce a sense of not wanting or caring to seek help even when necessitated. Implicit in the above result's outcome is that stigma is not culture free nor is it a biological trait. It is rather a process-encoded phenomenon in the human psyche over time that pervades every race (Anglin, Link, & Phelan, 2006), culture, and society (Gary, 2005).

Because stigma is perceived differently across cultures, the mental health profession may use this knowledge to work on finding effective ways to engage clients of different worldviews and or cultures during counseling. The impacts of stigma include low self-esteem and a sense of shame and isolation (Byrne, 2000; Gray, 2002). The condition is even more complicated when physical and mental health is indicated (Ward, Mertens, & Thomas, 1997). Further, it has been shown that there is a connection between self-concealment and help-seeking attitudes (Vogel & Armstrong, 2010).

Another explanation for the negative outcome of this hypothesis may be that individuals who suffer from mental health may prefer to keep their suffering private given that they will not like to be humiliated or treated differently. They may also be in denial. By being afraid, their mental health status may already be compromised. The ego denies or represses what it cannot handle (Psychoanalytic theory of Sigmund Freud in Corey, 2008).

Implications for Counseling Theory

For the African and or Nigerian American client, events in life are understood from a more holistic perspective which includes the self, extended family, community, universe, and the central spirit that governs everything. Therefore, it is believed that everything is in unison and a break from this affects all. Healing in this regard brings wholeness, balance, and progress hence, the expression I am because we are and vice versa principle (Mbiti, 1999).

This study shows that spirituality is important to the Nigerian American client. The mean score for all items was $M = 92.70$, $SD = 11.90$ indicating a strong belief in Afrocentric worldview and spirituality. This belief system informs every other value (family, work, community) and a belief that forces beyond one's control is at work. The implication for the counselor and theory is that current counseling theories do not include the concept of Afrocentric worldview and spirituality. The traditional theories and therapies were developed based on White middle class males' perceptions or worldview (Morris, 2001; Sue & Sue, 2004). The reality, however, is that increasingly more clients are from ethnic backgrounds different from the White middle class and as such differing

cultural worldviews. It has been noted also that attrition rates in counseling for ethnic

minority are high and one explanation for this is the traditional counseling or theoretical

orientation and styles used (Sue & Sue, 2004). For example, the most popular and

preferred therapeutic orientation is the cognitive-behavioral therapy (CBT) and the

predominant conceptual orientation is psychodynamic (Morris, 2001). CBT has

traditionally been conceptualized as a relatively value-neutral approach; however, CBT

and the other major practice theories are grounded in values of the dominant culture.

CBT places emphasis on assertiveness, personal independence, verbal ability, rationality,

cognition, and behavioral change. In contrast, African culture values subtle

communication over assertiveness, interdependence over personal independence,

listening and observing over talking, acceptance over behavioral change, a less linear

cognitive style and a more spiritually-oriented worldview (Jackson, Schmutzer, Wenzel,

& Tyler, 2006; Sue &Sue, 2004). It is therefore not surprising that clients of the lesser

dominant culture are seen to not benefit from current counseling care. A criticism of

psychodynamic grounding is its overemphasis on early development without considering

the client within a broader social context (Ainsle & Brabeck, 2003).

The value of this study's outcome would be its contribution to these salient

factors which are not currently incorporated in counseling theories and practices within

the United States in spite of the obvious trending in immigrant population particularly in

the last four decades (Dixon, 2006; Sue & Sue, 2008; U.S. Bureau of Census, 2010).

Generally, as discussed in earlier chapters at the surface level cultural factors such

as service access barriers and economic constraints in addition to variables such as

stigma, intentions, acculturation, and social economic status could account for why

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clients of African descent and of other ethnicities underutilized mental health services. Nevertheless, there is a deeper level that may explain these reasons; hence, the assertion that spirituality may be a strong influence. Westernized theoretical thinking may be inadequate in explaining every psychological mindset. In addition, traditional theoretical approaches and diagnostic tools may be insufficient in providing an adequate representation of the intrapersonal and interpersonal processes of immigrants, Nigerian American clients, and people of African descent in general. Traditional treatment approaches do not account for the impact of race, culture, and ethnicity in the United States (Morris, 2001; Sue & Sue, 2004).

For the Nigerian American client family, nuclear and extended, community, rites of passage in life and life after death have at the core the spirit. Finally, because spirituality is a core component of Nigerian life, it is reasonable to hypothesize that Nigerian Americans utilize their spiritual traditions as means of coping with daily life problems, rather than more formal Western approaches to psychological health such as seeking help from a mental health professional. Since this is a central theme that governs every aspect of the individual's life, therapy and/or theory that will work must attempt to include this in the process for a beneficial outcome.

Implications for Counseling Practice

This study revealed that spirituality was important in the life of Nigerian Americans regardless of age, gender, and socio economic status. All participants believed in a higher being. Further, almost all the participants will seek or have sought counseling through the clergy. More importantly, this study showed a strong relationship between

other stigma and spirituality. What then are the implications for counseling practice? Counseling professionals should be diligent about increasing awareness concerning the therapeutic values of spirituality in the overall wellbeing of this client population. As seen from this study's outcome, only 4% would seek formal counseling while the majority would first seek counsel from a clergy or traditionalist. This shows the importance of understanding and acknowledging the importance of spirituality in problem solving for this client group. Perhaps a willingness to work in collaboration with alternative practitioners should be considered (Sue & Sue, 2008). Queener and Martin (2001) highlighted the importance of collaboration between mental health counselors and the Black Church to provide psychological assistance to African Americans.

Further, an exploration of how their presenting problems are impacted by spirituality may help clients articulate and discern between mental health issues and spiritual needs. Because traditional theories and therapies are grounded in Western assumptions that compartmentalize problems, there is a high probability that many clinicians are not aware, knowledgeable, or skilled in working with ethnic clients of African descent (Morris, 2001) who view every aspect of life holistically. For example, therapeutic dyads such as independence, self-reliance, and/or being emotionally restrained may be counter intuitive to this kind of client; hence, the practitioner needs be appreciative of these dynamics' within the counseling milieu.

For the practitioner, awareness should include self-knowledge and then a genuine attempt to understand the clients' needs through their worldview. As stated earlier, the psychodynamic approach and the CBT emphasize individualism over collectivism; this

means that traditional modes of assessment, evaluation, and practices are conducted in the office settings which sometimes may be impersonal for this type of client. In addition, diagnostic tools such as the paper and pencil forms or question and answer style may be perceived as cold. In contrast, a more interpersonal style that combines client-centered approach and Gestalt plus a combination of conversation and question and answer style may be found more accepting. The practitioner's demeanor, attitude, and knowledge of African-centered thinking and perception could help reduce dropout rate, eliminate making faulty assumptions and/or challenging it. It will also reduce inaccurate diagnoses. It will reduce inappropriate treatment and assessment protocols and make way for collaborative treatment planning exercise which will encourage the client to stay committed to the counseling process. The African-centered perspective gives the service provider a foundation to understanding this type of client.

Also, stigma by others was found to be significantly correlated to spirituality. This indicates that when this type of client shows up for counseling, the practitioner must be cognizant and acknowledging of the seriousness of the issue and courage for presenting to mental health care. This sort of attitude from the practitioner will likely engender confidence, after all the issue is not whether the Nigerian American will seek counseling rather it is where as this study indicated that the clergy or traditionalist were usually sought even for mental health issues. Sensitively addressing "other" stigma and "self" stigma may also engender confidence and trust in the client that the practitioner cares and may be attentive to cultural other issues. For the Nigerian American client, the cognition that the therapist is open to all aspects of his or her worldview may be pertinent in reducing attrition to mental health counseling.

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This implies treatment modalities that are multidimensional in attitude, style, and knowledge rather than the narrower theoretical perspectives used in practice currently. These changes can be achieved through training and continuing education practices. Further, they should be incorporated into counselor education training and supervision.

Implications for Counselor Education

Knowledge gained from the present study has an impact on both counselor educators and supervisors. Counselor educators are responsible for educating and training potential counselors and can benefit from this research. This study shows that spirituality influenced other stigma. This is very important. Former studies disclosed that stigma of counseling was there, but no study went further to investigate the reason behind it, especially for clients of African descent. Stigma of counseling can now be articulated from a spiritual perspective thus giving the counselor educator an opportunity to include this finding in counselor training and supervision.

The implication is that the conception that stigma of counseling prevents clients from seeking therapy can now be examined further to include spirituality, and for the counselee who may want to seek help but is ill at ease with the perception that he or she may have defaced the community or family to which he or she belongs can also be addressed. It is necessary for the counselor educator to provide, train, and encourage discussions and experiences for counselor trainees to acquire the skills and reflexes to be able to explore and encourage clients. Beginning this at the training phase will encourage self-growth, skills acquisition, and comfort level needed in doing this kind of work with the "other" client or clients of African descent.

This study further revealed that clients of African descent and specifically Nigerian Americans are not necessarily averse to mental health counseling, rather their attitude and intention to seek mental health counseling may be dependent on their perception of the seriousness of their issues and the therapists' attitude and understanding of their intent and or perception of their problems. To this end, counselor educators may work to enlighten counselor trainees that mental health conceptualization and eventual intent to seek help may differ across different ethnic Americans. This is very important so that the counselor will be open to articulating clients' presentation from both cultural and worldview perspectives.

Knowledge and awareness precede skills. When counselor educators understand the psychological implications of African-centered values and their impact in the life of Nigerian Americans and/or people of African descent, counselor educators could use this knowledge to inform students of potential influences on the attitudes toward seeking formal counseling. Specifically, they could include examining the mindset of the client through their collective worldview; for example, a client who feels ashamed that going to counseling will "out" him as weak, guilty of doing something wrong to bring such punishment on family, or even a sense that one is suffering as a result of past wrong doing by a relative. The counselor educator can also use this knowledge to influence the structure of the counseling process such as teaching flexibility during intake assessment for such clients. Sue and Sue (2004) discussed that ethnic clients may not see anything wrong with the male member of the family speaking for the client during intake session or having the whole family present for therapy even though it is meant for one member of

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the family. Such knowledge during counselor training will reduce stereotypical thinking and assumptions.

The Council for Accreditation of Counseling and Related Educational Program (CACREP) is responsible for the standard of education and training for counselors in the U.S. even though there are openings for other countries should they choose to join. In the U.S. alone, there are 568 education program members and more institutions continue to apply and be accredited (CACREP, 2009). At this time, the standards set forth for multicultural training and competence include acquisition of knowledge, awareness, and skills. This section does not, however, break this down into specifics; for example, there is no mention of what or which ethnic skills, awareness, or competencies. There is no mention of African-centered psychology or theory among the traditional theories taught in theories of counseling as a CACREP accreditation standard. One possible explanation may be the multicomplex nature of the country's diverse cultural system which may be complex to articulate for both political and economic reasons. The standard highlights training in multicultural counseling but is not explicit to any cultural group. Perhaps, the competencies may need further elucidation for the purposes of breaking down the necessary skills and competences for each group. This will aid in course planning and management. Perhaps a core class in ethnic cultures for counselors may be considered as an option.

Also, the American Counseling Association (ACA) and the Ohio Counselors Association codes of practice each state that counseling outside of one's competencies is an ethical and professional breach of conduct. With regards to multicultural counseling therefore; counselor educators need articulate these principles in training so that

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counselors who wish to work with clients outside of their race and/or experiences will have a good chance of well-rounded education and training. It will reduce the confusion that may result when clients enter the counseling world only to drop out as a result of unspecified reasons or events

Limitations

The population used in this study was adult Nigerian Americans who immigrated to the U.S. after age 18. Most were highly educated and professional individuals presumably influenced to some degree by Western Judeo-Christian beliefs and practices. It is therefore important to be careful when extrapolating these results to the general population, specifically African immigrants (especially those with less than college education and of other religious beliefs).

A further limitation stems from the study design and definitions of the variables. For example, although the test instruments were valid and reliably researched, it is not clear how much they captured the essence of this study given that this may be one of the earlier times they are being used with this sample population for this specific topic. Specifically, The Intentions to Seek Counseling Scale included items that may not have been particularly perceived as debilitating to Nigerian Americans given their Bi or multicultural orientation that is distinct from the mainstream American culture.

Also, Spirituality as a variable has almost not been researched in this form. No study up to this date has sought to explain the origins of stigma on psychological help seeking from an Afrocentric perspective.

A further limitation to this study was instrument "over flood." By this, this researcher means flooding the study population with so many scales to fill out that this may have limited the quality of information obtained. With hindsight, it may have been beneficial to limit the scales to possibly not more than three and aimed at having subjects fill out over a period of time rather than face to face. One option could have been online administration which was not considered given the sample's perceived cultural outlook. The outcome, however, is immeasurable. It has opened the door to the quest for the origin of stigma as it relates to Afrocentric worldview and consequent influence on psychological help seeking.

The concept of Diunital cognition which is common to people of Afrocentric descent has been overlooked in conventional mental health treatments. Perhaps this is the time to incorporate this kind of cognition in counseling practices by researching it alongside conventional theories and techniques of counseling.

Finally, it is important to note that this study cannot infer causality given its exploratory nature. This study was an attempt to explain stigma of counseling from an Afrocentric Spirituality/worldview. This is not, however, meant to be taken that persons of Afrocentric worldviews may be averse to mental health counseling. Rather, an exploratory study of this nature could be further investigated in order to help in understanding the concept of stigma from a more dynamic origin as it relates to people of African descent.

Recommendations for Future Research

Future studies may wish to focus on Nigerians and other African immigrants in the United States, such as other West Africans and those from other parts of Africa, such as East and Southern African immigrants. This study was also an initial study of this phenomenon in an immigrant population. An expanded project with a larger study population could elicit further information and allow for clarification of observations made here. It may be conducted at an institutional level with adequate funding and more human resources to administer and collect data.

Although this study did not necessarily invalidate the instrument used to assess intentions to seek counseling, future research could focus on modifying the items in this instrument to adequately elicit information that may have been suppressed or covered by this sample's education and sociocultural levels/experience. A simple way to start could be a pilot study on items that this sample population will perceive as serious enough to warrant professional mental health help.

The researcher believes that taboos have a strong effect on behavior and self-disclosure of information by people from areas that still have intact cultures such as Africans in general. Perhaps additional studies designing instruments for eliciting the influence of taboos in the study population may lead to less inhibited or socially desirable responses. It is hoped that when people identify with similar problem items, the more likely they will be disposed to giving genuine responses.

There is need for qualitative study of this topic as personal interviews would help to shed more light on Nigerian immigrants' attitudes toward seeking professional psychological help. Spending some time with this population may produce further results

on the attitudes of Nigerian immigrants in this regard. Again, developing an acculturation scale for Nigerian population is important in identifying the level of acculturation of Nigerian immigrants to the dominant culture. This would be better than an individual self-report, which may not be very accurate due to individual understanding of the questions and method of response.

There would be need to conduct specific research on this topic, for instance, on the attitudes of Nigerian college students in the United States. Since students may be more familiar with the benefits of mental health services, a study in this direction would explain further how Nigerian students would respond to seeking professional psychological help in comparison to studies done among students of other ethnic groups. Studies on other Nigerian professionals would also be helpful.

Furthermore, conducting research on the actual use of professional psychological help by Nigerian immigrants as opposed to understanding the demographic relationship might explain not only their disposition to seeking such help but also conditions that may favor or disfavor their attitudes. Again, since demographic factors did not favor stigma tolerance among Nigerian immigrants, there is need for further study on what can be done to increase stigma tolerance among this population. There is also need to study Nigerian immigrants' preference of mental health providers because demographic factors did not support any trust or confidence in mental health providers. This would help to identify who the Nigerian immigrants would regard as being competent in handling their psychological and emotional problems.

Finally, the fact that more than half of the participants in this study reported past contact with spiritual leaders suggests a need to conduct research on Nigerian immigrants'

attitudes toward spirituality in counseling to know if more Nigerian immigrants will

participate in counseling with spiritual components.

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APPENDICES

APPENDIX A

INFORMED CONSENT

You are invited to participate in a research project being conducted by Maryann O. Meniru, a doctoral candidate in the Department of Counseling at The University of Akron, in Akron, Ohio. This study will examine how spirituality influences the attitude of Nigerian Americans toward seeking counseling. The purpose of this study is to help mental health professionals (counselors, social workers, psychologists and psychiatrists in the U.S.) understand Nigerian culture and spirituality in the life of Nigerian Americans. Only Nigerian Americans immigrating to the U.S. at age 18 or older are invited to participate in this study.

If you agree to participate, you will be asked to give general information that describes you, and to complete five brief questionnaires. Questions target the way you think or feel toward professional counseling and in general. It should take approximately 15-20 minutes to complete your responses. As a participant, you will not receive direct benefits from this study but your participation may add to the body of knowledge and understanding regarding cultural differences among ethnic groups (which include Nigerian Americans) in the United States regarding mental health or counseling. Also, if you choose, your name will be entered to be randomly selected to receive a gift certificate to a restaurant in your area.

Your participation in this study is voluntary. You are free to refuse to participate or to withdraw at any time without negative consequences. No known risk or discomforts to research participants are expected. All information will remain anonymous. No identifying data will be collected and your anonymity is further protected by not asking you to sign and return informed consent document. Confidentiality will be maintained using a number code system that will be assigned into a password protected computer and completed questionnaire packets will be stored in a locked filing cabinet.

Your completion and return of this packet will serve as your acceptance of the information provided in this informed consent document and your consent to participate in this study. You will be given a copy of this informed consent document to keep for future reference. If you have any questions about this study, you can contact Maryann O. Meniru by emailing her at mom1@zips.uakron.edu or calling 3306851088. You can also contact Dr. Robert C. Schwartz, PhD, Dissertation chair and professor at the University of Akron in Akron Ohio at rcs@uakron.edu or by calling 330 972 8155.

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE/PERSONAL DATA FORM/ EXTRA

Please answer the following by *circling or filling* **in** your choices.

1. What is your sex?

      Male---------------

      Female------------------

2. What is your marital status? (1)   married   (2) Single (3) Living with a partner

3. What is your age? ……………………………..

4. At what age did you immigrate to the U. S.? …………………………….

5. What is the highest level of education you have completed?

    (1) elementary   (2) junior High School   (3) High School

    (4) Associate Degree   (5) Bachelors Degree   (6) Masters Degree

     (7) Doctoral Degree

6. In what U. S. State do you reside? ………………………….

7. Have you ever sought counseling help from a spiritual leader for life problems?

      (1) YES   (2) NO

8. If you were going to seek help for life problems/concerns, who would you prefer?

      (1) Mental health professional   (2) Minister/Clergy/Imam/Spiritual healer

      (3) Friends   (4) Medical doctor

APPENDIX C

SPIRITUALITY SCALE

Instructions: The items on this questionnaire each consists of a single statement. Under each statement there is a scale ranging from 1 to 6. In each instance, these numbers mean the following. Using this scale, please respond to each statement by **circling the number which best represents the degree to which the statement is true or false for you**.

> 1 = completely false
> 2 = mostly false
> 3 = somewhat false (more false than true)
> 4 = somewhat true (more true than false)
> 5 = mostly true
> 6 = completely true

1. To me, every object has some amount of spiritual quality.

      1   2   3   4   5   6

2. To have faith in each other is to have faith in God.

      1   2   3   4   5   6

3. I pray before taking a test.

      1   2   3   4   5   6

4. I believe that the world is not under our control but is guided by a greater force.

      1   2   3   4   5   6

5. I believe more in politics than in religion as a way for people to come together.

      1   2   3   4   5   6

6. All people have a common core which is sacred.

      1   2   3   4   5   6

7. I act as thought unseen forces are at work.

      1   2   3   4   5   6

1 = completely false
2 = mostly false
3 = somewhat false (more false than true)
4 = somewhat true (more true than false)
5 = mostly true
6 = completely true

8. We all need to have knowledge of the world's religions.

     1   2   3   4   5   6

9. Just because I have faith and beliefs does not mean I live that way all the time.

     1   2   3   4   5   6

10. No preacher could ever understand the problems I have.

     1   2   3   4   5   6

11. Without some form of spiritual help, there is little hope in life.

     1   2   3   4   5   6

12. I pray before eating a meal.

     1   2   3   4   5   6

13. The most important part of me is the inner force which gives me life.

     1   2   3   4   5   6

14. My happiness is found in material good I own.

     1   2   3   4   5   6

15. I feel that all life is simply made up of different chemicals.

     1   2   3   4   5   6

16. I pray before going on a trip.

     1   2   3   4   5   6

17. To me, the world can be described as a big machine.

     1   2   3   4   5   6

18. If I had more money, life would be happier.

     1   2   3   4   5   6

19. I don't know where to find answers to life's questions.

      1   2   3   4   5   6

20. To me, an object's material worth is that object's value.

      1   2   3   4   5   6

21. Though I may go to a doctor when I am ill, I also pray.

      1   2   3   4   5   6

22. The truth is what we learn in school.

      1   2   3   4   5   6

23. To me, it is possible to get in touch with the spiritual world.

      1   2   3   4   5   6

24. Since science and church both have an idea about man's beginnings, I don't know which is true.

      1   2   3   4   5   6

25. I feel that life is made up of spiritual forces.

      1   2   3   4   5   6

APPENDIX D

PERCEPTIONS OF STIGMATIZATION BY OTHERS FOR SEEKING

PSYCHOLOGICAL HELP SCALE

Instructions: Please respond to the following items as accurately and honestly as possible. There are no wrong answers. It is important that you answer every item.

Circle the number that corresponds to your observation.

Imagine you had a problem that needed to be treated by a mental health professional and if you sought mental health services, to what degree do you believe that family and friends would………………

Not at all (1)   Slightly (2)   Somewhat (3)   Moderately (4)   A great deal (5)

1.	Think of you in less favorable way	1	2	3	4	5
2.	Think bad of you	1	2	3	4	5
3.	React negatively to you	1	2	3	4	5
4.	See you as seriously disturbed	1	2	3	4	5
5.	Think you posed a risk to others	1	2	3	4	5

APPENDIX E

SELF STIGMA OF SEEKING HELP

Instructions: Please use this 5-point scale to rate the degree to which you may feel should you find yourself in this situation.

Note: The term professional mental health services refer to any services provided by the following professionals: psychologist, psychiatrist, counselor or clinical social worker.

Strongly disagree (1) Disagree (2)   Agree or Disagree equally (3)   Agree (4)
Strongly Agree (5)

1. I would feel inadequate if I went to a mental health professional for psychological

    help**.**   **1**   **2**   **3**   **4**   **5**

2. My self confidence would NOT be threatened if I sought professional mental health

    services   **1**   **2**   **3**   **4**   **5**

3. Seeking psychological help would make me feel less intelligent

    1   **2**   **3**   **4**   **5**

4. My self esteem would increase if I talked to a mental health professional

    1   **2**   **3**   **4**   **5**

5. My view of myself would not change just because I made the choice to see a mental

    health professional

    1   **2**   **3**   **4**   **5**

6. It would make me feel more inferior to ask a mental health professional for help

1   **2**   **3**   **4**   **5**

7. I would feel OK about myself if I made the choice to seek professional mental health services   **1**   **2**   **3**   **4**   **5**

8. If I went to a mental health professional, I would be less satisfied with myself

1   **2**   **3**   **4**   **5**

9. My self confidence would remain the same if I sought professional mental health services for a problem I could not solve

1   **2**   **3**   **4**   **5**

10. I would feel worse about myself if I could not solve my own problems

1   **2**   **3**   **4**   **5**

APPENDIX F

INTENTIONS OF SEEKING COUNSELING INVENTORY

Instructions: Please rate the likeliness that you would see a mental health professional if you were experiencing one/any of the following problems.

	Very Unlikely	Unlikely	Somewhat Unlikely	Somewhat Likely	Likely	Very Likely
1. Weight control	1	2	3	4	5	6
2. Excessive alcohol use	1	2	3	4	5	6
3. Relationship difficulties	1	2	3	4	5	6
4. Concerns about sexuality	1	2	3	4	5	6
5. Depression	1	2	3	4	5	6
6. Conflicts with parents	1	2	3	4	5	6
7. Speech anxiety	1	2	3	4	5	6
8. Dating difficulties	1	2	3	4	5	6
9. Choosing a major	1	2	3	4	5	6
10. Difficulty in sleeping	1	2	3	4	5	6
11. Drug problems	1	2	3	4	5	6
12. Inferiority feelings	1	2	3	4	5	6
13. Test anxiety	1	2	3	4	5	6
14. Difficulties with friends	1	2	3	4	5	6
15. Academic work procrastination	1	2	3	4	5	6
16. Self-understanding	1	2	3	4	5	6
17. Loneliness	1	2	3	4	5	6

ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL

HELP SCALE - ABBREVIATED FORM

Instructions: For each statement below, decide whether you **disagree, somewhat disagree, somewhat agree or disagree or agree.** *Circle your numbered response.*

For this survey, the term "professional mental health/professional" refers to any services provided by the following persons: psychologist, psychiatrist, counselor or clinical social worker.

0	1	2	3
Disagree	Somewhat Disagree	Somewhat Agree	Agree

1. If I believed I was having mental health difficulties, my first inclination would be to seek professional attention

0	1	2	3
Disagree	Somewhat Disagree	Somewhat Agree	Agree

2. The idea of talking about problems with a mental health professional strikes me as a poor way of getting rid of emotional conflicts

0	1	2	3
Disagree	Somewhat Disagree	Somewhat Agree	Agree

3. If I were experiencing serious emotional crises at this point in my life, I would be confident that I could find relief in professional mental health services

0	1	2	3
Disagree	Somewhat Disagree	Somewhat Agree	Agree

4. There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without resorting to professional mental health services .

0	1	2	3
Disagree	Somewhat Disagree	Somewhat Agree	Agree

5. I would want to get professional mental health services If I were worried or upset for a long period of time.

0	1	2	3
Disagree	Somewhat Disagree	Somewhat Agree	Agree

6. I might want to have professional mental health services in the future

0	1	2	3
Disagree	Somewhat Disagree	Somewhat Agree	Agree

7. A person with an emotional problem is not likely to solve it alone, he or she is likely to solve it with professional mental health services

0	1	2	3
Disagree	Somewhat Disagree	Somewhat Agree	Agree

8. Considering time and expense involved with professional mental health services, it would have doubtful value for a person like me

0	1	2	3
Disagree	Somewhat Disagree	Somewhat Agree	Agree

9. A person should work out his or her own problems; getting professional mental health services would be a last resort

0	1	2	3
Disagree	Somewhat Disagree	Somewhat Agree	Agree

10. Personal and emotional troubles, like many other things tend to work out by themselves

0	1	2	3
Disagree	Somewhat Disagree	Somewhat Agree	Agree