6-2017

Attitudes toward Professional Psychological Help among Kenyan Immigrants Living in the United States

Reuben M. Mwangi

Western Michigan University, kariangin7@gmail.com

Follow this and additional works at: http://scholarworks.wmich.edu/dissertations

Part of the Counseling Commons, and the Counseling Psychology Commons

Recommended Citation

http://scholarworks.wmich.edu/dissertations/3130

This Dissertation-Open Access is brought to you for free and open access by the Graduate College at ScholarWorks at WMU. It has been accepted for inclusion in Dissertations by an authorized administrator of ScholarWorks at WMU. For more information, please contact maira.bundza@wmich.edu.
ATTITUDES TOWARD PROFESSIONAL PSYCHOLOGICAL HELP AMONG KENYAN IMMIGRANTS LIVING IN THE UNITED STATES

by

Reuben M. Mwangi

A dissertation submitted to the Graduate College in partial fulfillment of the requirements for the degree of Doctor of Philosophy Counselor Education and Counseling Psychology Western Michigan University June 2017

Dissertation Committee:

Mary L. Anderson, Ph.D., Chair
Stephen E. Craig, Ph.D.
Evelyn Winfield-Thomas, Ph.D.
Many Kenyans experience long-standing deleterious life events (e.g., inter-ethnic violence, terrorism, major disasters) in their home nation, and may vicariously experience additional stressors as they seek to acculturate and pursue their ambitions in the United States. Despite experiencing events that may have significant mental health implications, it is unclear how or whether Kenyan immigrants seek professional counseling to enhance their overall mental health and wellness.

The purpose of this study was first to examine the relationship between demographic variables (i.e., gender, education, and marital status) and attitudes toward seeking professional psychological counseling for Kenyan immigrants in the United States. Second, this study also sought to examine the relationship between spiritual well-being, level of psychological acculturation, and attitudes toward seeking professional psychological help. The sample included 279 (141 paper/pencil and 138 online) adult Kenyan immigrants in the United States. Participants completed a demographic questionnaire that included psychological acculturation questions, the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH; Fischer & Turner, 1970), and the Spiritual Well-Being Scale (SWBS; Paloutzian & Ellison, 1991).
Contrary to initial expectations, results from a three-way factorial ANOVA indicated neither gender nor education, nor marital status has any statistically significant effect on attitudes toward professional psychological help. General linear multiple regression also showed that spiritual well-being and acculturation were not statistically significant predictors of attitudes toward seeking professional psychological help for Kenyan immigrants in the United States. Within the study, key terms are defined and operationalized for purposes of this research. Implications for counseling practice, theory, and counselor education, in addition to recommendations for future research, are discussed.
ACKNOWLEDGMENTS

“Great is thy faithfulness, O God my Father,

There is no shadow of turning with Thee;

Thou changest not, Thy compassion, they fail not,

As thou hast been thou forever will be

…All I have needed Thy hand hath provided—‘Great is thy faithfulness’ Lord unto me!”

—Thomas Chisholm

“For in Him we live and move and have our being…”

—Acts of Apostles 17:28 KJV

The doxology, “Praise God, from whom all blessings flow!” sums up my heartfelt gratitude to God. My doctoral studies would not have been possible without God’s sustaining power. For this reason, I will ever praise His name.

My most sincere gratitude goes to my doctoral advisors, Dr. Mary L. Anderson, Dr. Stephen Craig, and Dr. Evelyn Winfield-Thomas for their deft guidance and helping me to navigate my doctoral studies. I particularly thank my doctoral chair, Dr. Mary L. Anderson, for your support, advising, insight, and helpful suggestions. Thank you for your mentorship throughout my studies and in developing my professional identity. I appreciate Dr. Craig, the Immediate Past-President of North Central ACES, for providing constructive feedback, and broadening and challenging me to enhance my academic and professional competence. Dr. Winfield-Thomas, I thank you for directing me in my research work and inspiring me with words of encouragement. Your concerted effort in
Acknowledgments—Continued

this endeavor has brought me this far. I will be forever indebted to Dr. Suzanne Hedstrom and Dr. Gary Bischof for their advice during the formative stage of my doctoral studies. I am grateful to Dr. Darryl Plunkett, Dr. Katie Bozek, and Dr. Jennifer Foster for providing valuable feedback during my internship teaching experience.

I cannot forget Ms. Julie Scott, Systems Specialist at the Office of Information Technology, who managed the online data collection process. I am so very thankful for your time. I especially want to thank Dr. Janeé Steele for your valuable guidance in data management and consultancy. I would be remiss if I fail to express my gratitude to my studious cohorts Rommel Johnson and Heather Highhouse for your support and thoughtfulness, together with others who had an impact on my life: Ashley Wildman, Damon Chambers, and Cheruba Daniel.

Importantly, in the spirit of Kenyan Harambee, this study was made possible through the effort of a willing group of participants. In addition, church leaders allowed me to visit their faith communities and organizations and supported me during the data collection stage. I am appreciative to Pastor John Mondi of Grand Rapids Kenyan Fellowship and Pastor Joseph Karanja of the Michiana area for your timely facilitation in data collection. Mr. Maina Ndigiĩgĩ, your wife Lucy Nduta, and zealous children, Ngũnyi-CN, Tetũ, Mũũiĩthi, and Mũũmbi of the mid-western area: I am proud of you. To my brother Guchu Mwangi and his lovely family who coordinated in the Central-Southern States, may you be blessed. The collaboration was quite fruitful. Remember the
African proverb from our mother, ‘Thegere ĩgĩrĩ itiremagūo nǐ mwatũ.’ Two ‘thegeres’ (cat-like mammals) are able to pull a beehive down from a tree.

My hats off to the many brilliant boys and girls in my village who hastily dropped out of elementary school due to the intolerable life circumstances and lack of sufficient resources. I would have loved to travel this journey with you. My Church family has been quite an oasis of hope and rejuvenation. With a sense of expectancy, I looked forward to “come and rest awhile” for prayers and wellness during my academic journey. It is my wish that my effort and accomplishments will be worthwhile to make a difference in people’s lives, as I endeavor to serve God and humanity.

I wish to express my deepest appreciation to my dear wife Ruth for holding the fort while I was away. Your sacrifice and moral and emotional support will ever be treasured. You deserve the best. I thank my children Mwangi and Wanjiũrũ for your untrammeled courage, resilience, patience, and understanding. It’s over! Well, the nostalgia of the indelible images of my leafy village in Kenya, conjures up memories of an intact close-knit family. Who can forget the gourd milk, the get-together, the bleating sheep, and the fireside evenings? The irreparable social dislocation caused by traveling to a foreign country has been moderated by the love and warmth I always find in you. To my larger family in Kenya and elsewhere, I thank you for putting up with my absence and holding me accountable.

In closing, I want to thank my mother, Sarah Mwangi, who has been my source of inspiration and strength. Your unparalleled love for wisdom is amazing. I treasure your
counsel. My late father, Pastor James Mwangi, went to rest halfway through my doctoral studies. My father always prayed for and with me. He challenged me to take the road less travelled, strive for the best, and never to rest on one’s laurel in keeping with the famous poem: “Good, better, best. Never let it rest. Until your good is better, and your better is best.”

Reuben M. Mwangi
TABLE OF CONTENTS

ACKNOWLEDGMENTS ........................................................................................................ ii
LIST OF TABLES .................................................................................................................. xi
LIST OF FIGURES ............................................................................................................... xii

CHAPTER

I. INTRODUCTION .................................................................................................................. 1
   Background of the Study .................................................................................................... 1
   Statement of the Problem .................................................................................................. 6
   Purpose of the Study ....................................................................................................... 10
   Research Questions and Hypotheses ............................................................................... 10
   Theoretical Framework .................................................................................................... 11
   The Significance of the Study .......................................................................................... 14
   Definition of Terms ........................................................................................................ 16
   Summary .......................................................................................................................... 18

II. REVIEW OF LITERATURE .............................................................................................. 20
   Kenyan Immigrants in the United States ........................................................................ 20
   Historical, Socioeconomic, and Cultural Contexts From Which Kenyans Immigrate ...... 24
      Historical Context ....................................................................................................... 24
      Socioeconomic Context ............................................................................................. 29
      Cultural Context ......................................................................................................... 31
# Table of Contents—Continued

## CHAPTER

Mental Health Concerns of Kenyan Immigrants Living in the United States ................................................................. 33

   Traditional Male Norms .................................................................................................................. 34

   Domestic Violence ......................................................................................................................... 35

   Challenges in Parenting ............................................................................................................... 35

   Problems in the Academic Success of Children ........................................................................ 37

   Employment and Skills Transferability ..................................................................................... 38

Perceived Barriers to Care .................................................................................................................. 38

   Health Insurance Coverage and Affordability ........................................................................... 40

   Cultural Beliefs and Stigma ........................................................................................................ 41

Attitudes Toward Seeking Professional Counseling ........................................................................ 43

Coping and Spiritual Well-Being .................................................................................................... 47

   Coping in Symbolism and Metaphors ...................................................................................... 47

   Spiritual Well-Being ................................................................................................................... 48

Contrast of Western and Afrocentric Thought .............................................................................. 50

   Wisdom of the African Elders Preferred ................................................................................ 52

   African Ubuntu-ism and Mental Health .................................................................................... 54

Summary ........................................................................................................................................... 55

## III. RESEARCH METHODOLOGY

Research Questions and Hypotheses .......................................................................................... 56

Research Design ........................................................................................................................... 57
CHAPTER

Participants and Sampling Methods .......................................................... 57
  Inclusionary Criteria .............................................................................. 58
  Exclusionary Criteria ............................................................................ 59
Risks and Protection of Participants .......................................................... 59
Benefits of the Research ......................................................................... 59
Confidentiality of the Data ...................................................................... 59
Instrumentation ....................................................................................... 60
  Demographic Questionnaire ................................................................. 60
  Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) .................................................................................. 60
  Spiritual Well-Being Scale (SWBS) ......................................................... 61
Data Collection Procedures .................................................................... 63
Data Analysis ............................................................................................ 64
  Research Question 1 ............................................................................ 65
  Research Question 2 ............................................................................ 65
Summary ................................................................................................... 66

IV. RESULTS ................................................................................................ 67
  Description of Participants .................................................................... 67
  Descriptive Statistics ........................................................................... 72
  Internal Consistency Reliability Scores .................................................. 77
  Research Question 1 ............................................................................ 77
Table of Contents—Continued

CHAPTER

Multicollinearity .................................................................................. 78
Collapsed Variables ................................................................................ 79
Homogeneity of Variance-Covariance Matrices and Equality of Variance ................................................................. 79
Results ........................................................................................................ 80
Research Question 2 ................................................................................... 83
Multicollinearity ....................................................................................... 83
Normal Probability Plot of the Regression Standardized Residual and Scatterplot ............................................................ 84
Results ........................................................................................................ 85
Summary of Results ................................................................................... 86
Hypothesis 1 ............................................................................................. 86
Hypothesis 2 ............................................................................................. 86

V. DISCUSSION AND IMPLICATIONS ......................................................... 87

Overview of the Study ............................................................................... 87
Discussion of the Results .......................................................................... 88
Demographic Characteristics ..................................................................... 89
Research Question 1 ................................................................................. 93
Research Question 2 ................................................................................. 96
Implications for Theory and Practice ....................................................... 98
Limitations ................................................................................................ 102
# Table of Contents—Continued

## CHAPTER

Recommendation for Future Research ........................................ 104

Conclusion .................................................................................. 105

## REFERENCES ........................................................................... 107

## APPENDICES .......................................................................... 129

A. Demographic Questionnaire ...................................................... 129

B. Attitudes Toward Seeking Professional Help Scale (ATSPHS)........ 134

C. Spiritual Well-Being Scale ........................................................ 139

D. Invitation to Participate in the Study, Script for Potential Participants, and Email to Online Participants .................................................. 141

E. Informed Consent Document...................................................... 145

F. Follow-up Invitation to Participate in Study ............................... 148

G. HSIRB Approval Document....................................................... 150
# LIST OF TABLES

1. Summary Description of Participants ................................................................. 70

2. Descriptive Statistics for the Total ATSPPHS, ATSPPH Subscales, Total SWB, SWB Subscales, and Total Psychological Acculturation ........................................... 73

3. Descriptive Statistics for ATSPPH Items ............................................................ 73

4. Descriptive Statistics for Spiritual Well-Being Items ........................................... 75

5. Descriptive Statistics for Acculturation Items ...................................................... 76

6. Internal Reliability Consistency Scores ............................................................... 77

7. Pearson’s Correlations of Dependent Variables ................................................... 78

8. Summary of Regression Analysis for Total SWB, Acculturation, and Total ATSPPHS ............................................................................................................. 85
LIST OF FIGURES

1. Bronfenbrenner’s biological model of human development. ........................................ 13
2. Mean total ATSPPHS for gender.................................................................................. 80
3. Mean total ATSPPHS for education............................................................................. 81
4. Mean total ATSPPHS for marital status ....................................................................... 82
5. Normal probability plots of the regression standardized residual. ............................... 84
6. Scatter plot of standardized residuals. ........................................................................ 85
CHAPTER I

INTRODUCTION

The Western concept of professional counseling is new in Kenya. The Western approaches to the therapeutic relationship generally include a collaborative engagement between therapist and client whereby both are bound to change through a therapeutic venture (Corey, 2013). African communities may be unfamiliar with conventional counseling due to the great disparity between the worldview behind Western psychotherapy and that of African communities (Neki, Joinet, Hogan, Hauli & Kilonzo, 1985). Traditionally, in Kenya, it is assumed that personal, family, or social issues are best resolved privately, and that exposure of these issues would taint or stigmatize the reputation of the family. When personal or family problems cannot be resolved privately, well-respected relatives, clan elders, or traditional healers are consulted (Okech & Kimemia, 2012). Consulting with a stranger—even a professional—about personal or family problems had been unusual among Africans (Nwadiora, 1996); however, with the increasing availability of professional counseling, Kenyan attitudes toward the utilization of mental health services may be gradually evolving. To date, there are few studies that explore Kenyans’ attitudes toward mental health services. This study will explore attitudes toward seeking professional psychological help among Kenyan immigrants living in the United States. The study will also explore the relationships among those attitudes, various demographic characteristics, and spiritual well-being.

Background of the Study

Many Kenyan immigrants have experienced adverse life events, for example ethnic violence, while living in Kenya. After arriving to the United States, daily stressors
often compound the trauma associated with these life events. Some of these stressors include prevalence of domestic violence and homicides (Muriithi, 2011), marital problems, parenting challenges, underemployment, transnationalism and remittance challenges, overburdened work responsibilities necessary to support extended families (Muriithi, 2012), acculturation problems, and perceived racism and alienation (Muriithi, 2013). Each stressor has important mental health implications. Yet, despite the fact that there is an apparent need for mental health services, it is unclear how Kenyan immigrants in the United States view professional counseling services.

According to the literature, many Kenyans are accustomed to a medical model that adheres to drug-based treatment for mental health problems (Ndetei, 2001). Ndetei conducted a foundational study titled, “Psychiatry in Kenya: Yesterday, Today and Tomorrow” that was instrumental in the field of mental health. The purpose of the study was to review progress made in how mental illness, treatment modalities, and delivery of services are understood in Kenya. Findings revealed psychiatrists dominated the field of mental health in Kenya, and almost exclusively provided mental health treatment through the use of medication. A primary conclusion of the study, therefore, was Kenya had a dire need for trained mental health specialists. The results of this study highlighted the scarcity of practitioners, reporting that by 1979, the psychiatrist-population ratio in Kenya was 9 practitioners to about 15 million Kenyans, and only one medical school. In comparison, South Africa had 200 psychiatrists for a population of about 35 million in 1963.

The scarcity of professional mental health practitioners in Kenya continues to be an issue of great concern. Currently, the ratio stands at approximately 88 urban-based
psychiatrists for a population of 46 million, or 1:522,727 thus compounding the problem of availability, accessibility, and affordability of mental health services. Unfortunately, Kenya’s only mental health hospital was underfunded, understaffed, and publicly eschewed. From its inception in 1911 through 1950, the Nairobi Lunatic Asylum (now the Mathari Mental Hospital), the national referral institution, was the only hospital in the country offering inpatient, custodial mental health services (Dhadphale & Magu, 1984; Ndetei, 2001). Today, anyone seeking mental health services through the Mathari Mental Hospital is likely to be stigmatized and ostracized.

The stigma associated with poor mental health is compounded by the Mathari Mental Hospital’s unpleasant aesthetic appeal and inhumane environment for patients and visitors. To date, the entrance signpost to the hospital is unwelcoming and reads: “Maximum Security Unit, No Unauthorized Person Allowed Beyond This Point.” The overwhelming majority of severely impaired and involuntary patients with high-risk psychopathological disorders further complicates the stigma associated with the Mathari Mental Hospital, and discourages individuals with less severe symptomatology from seeking help. Treatment at the hospital may complicate social acceptance and friendships. It is difficult to fit in society once discharged from the hospital, as summarized by one hospital patient’s own complaint:

We are simply labeled ‘Mathari cases.’ If we laugh, we laugh like Mathari cases. If we weep, we weep like Mathari cases. If we have wonderful ideas, they are from Mathari cases. There is nothing we can do good or bad without it being dismissed as coming from Mathari case. (Ndetei, 2001, p. 40)
While there is a great deal of stigma associated with mental health treatment in Kenya, there have been some revolutionary developments in the provision of services. One such development was the passing of the 1989 Mental Health Act, which decentralized mental health care from care being provided mainly by specialists based at the national psychiatric hospital, to care provided by general workers based in district hospitals and primary care centers (Muga & Jenkins, 2008). Despite concerted efforts to educate the public regarding mental health and the decentralization of treatment services to district hospitals, Muga and Jenkins (2008) found that the public viewed hospitals as dispensers of medicine and not therapeutic interventions or consolation. Similarly, counseling or talk therapy to alleviate mental health problems was still unfamiliar to the public. Previous policies based on the “pill for every ill” medical model were popular, which had little consideration of the psychological and social aspects of illness (Muga & Jenkins, 2008). It seems that Kenyan mental health practitioners describe mental health from a deficit model of curing those struggling with mental health concerns, with little attention to strengths or attending to normative life situations and challenges.

Some cultural beliefs could possibly pose barriers for help seeking behaviors. Cultural beliefs about the causes of mental illness are similar across cultural and ethnic groups in Kenya, and include: (a) mental health disorders are caused by supernatural powers (e.g., evil spirits and gods), (b) those who develop mental disorders do so to atone for sins committed by the clan against the ancestors, and (c) those who develop mental disorders do so as a result of being bewitched (Kiima, Njenga, Okonji, & Kigamwa, 2004).
Kenyans, like in other African cultures, describe and interpret illness and mental health problems from a spiritual point of view. Kenyatta (1953) conducted anthropological studies among the Kikuyu people group of Central Kenya, and found that illnesses that seemed to defy the wisdom of man were attributed to a supernatural power, or to the agency of evil ancestral spirits. When dealing with these illnesses, a medicine man or magician, when consulted, employ strategies including prophecy, purification, divination, and the cursing of sickness. Similarly, the Abaluhyia of Western Kenya attribute illnesses to multiple causes, including human factors, transgressions against taboos, spiritual factors, and environmental pollution (Wandibba, 1995). Overall, in popular African culture, the root cause of much illness and misfortune can be directly attributed to conflicts in interpersonal relationships that feature both horizontal (i.e., kinfolk, neighbors, co-workers) and vertical (i.e., relations with the ‘living dead’ ancestral spirits) dimensions (Mbiti, 1969). Suffering, misfortune, disease, and accident are all “caused” mystically, as far as African people are concerned.

To illustrate the connection between spirituality and perceptions of mental illness, Comaroff (1980) used the example of the Barong Boo Ratshidi ethnic group of South Africa to explain basic beliefs regarding health and affliction that can be found in many African communities. The researcher argued that a people’s cosmology (i.e., their perception of the world as it inheres in the context of action and experience) is predicated upon the deeper structural order. To be in good health, which is the same as being “one’s self,” connotes a positive existence, or a harmonious relationship and control over the environment which would otherwise threaten to swamp one’s identity (Comaroff, 1980). Affliction of any kind is therefore explained as “the dislocation of the self and its social...
and cosmic context” (Comaroff, 1980, p. 637). According to Comaroff (1980), “Healing thus entails the manipulation of the multi vocal symbolic media, seeking to reintegrate the physical, conceptual, and social universe of the sufferer and community, objectification and restructuring of such dislocation” (p. 637).

According to Biney (2007), spirituality involves the fostering and maintenance of a harmonious relationship between humanity, and natural and supernatural forces such as God, the divinities, ancestors, and the environment. Importantly, Mbiti (1969) a theologian and prominent scholar of African religious philosophy asserted, “Africans are notoriously religious,” carrying their religion within them wherever they go (p. 1). The vast majority of Kenyans are Christian (83%), with 48% being Protestant, 23% being Catholic of the Latin Rite, and the remaining belonging to other conservative churches. Sizeable minorities are comprised of Muslim (11%) and Traditionalist (1.7%) religions, among others (Kenya National Bureau of Statistics, 2010). Biney (2007) further argued that African spirituality, often expressed through such avenues as formal worship, prayer, song, myth, art, and naming practices, has proven to be one of the most enduring aspects of African identity on the African continent and in the diaspora. African spirituality is “never disembodied but always integrally connected with the movement of life” (Biney, 2007, p. 266, as cited in Olupona & Gemignani, 2007).

Statement of the Problem

Given the complexity of mental health issues among Kenyan immigrants (e.g., pre and post immigration stressors, negative life events, daily stressors, transnational issues of disasters in Kenya, trauma associated with political upheavals such as paroxysms of poll-ethnic violence, health care difficulties, insecurity and dislocation of traditional
family unit), more information is needed regarding Kenyan immigrants’ attitudes toward seeking professional help. Moreover, there are currently no existing studies informing how spirituality correlates with help-seeking attitudes of professional counseling services among Kenyan immigrants in the United States. This researcher seeks to fill this void by providing empirical data that will describe Kenyan immigrants’ perceptions, attitudes, and utilization of professional counseling. This study will potentially clarify existing assumptions and provide information regarding how Kenyan immigrants manage mental health challenges, who they prefer to consult, and whether they access counseling services that were previously unavailable and occasionally unaffordable in Kenya.

In particular, there is a remarkable influx of Kenyans living in the United States over the last two decades. According to Capps, McCabe and Fix (2011), Black Africans are a small but rapidly rising new immigrant population in the United States, growing by 88% from 2000 to 2009. These individuals often immigrate to pursue better economic and educational opportunities. Conservative figures estimate a population of 90,000 Kenyans living in the United States, making Kenya among the top five countries with immigrants in the country (Capps et al., 2011). There is national interest in Kenyans living in the United States due to their transnational ties and their economic contribution to the Kenyan economy in the form of financial remittances (Kioko, 2011).

Black and Jackson (2005) found that a tremendous emotional toll is exacted when people leave their families. Immigrants have a sense of loss of the actual family bond and social dislocation, and experience difficulties of coping and assimilation in a new and sometimes hostile environment. Immigration often causes alienation from one’s community, an organic whole of which the individual is a part. This organic whole pre-
existed before the individual and comprises not only the living human being, but also the living dead and the unborn (Olupona, 2007). Immigrants from Kenya come from a country with meager resources and underdeveloped professional counseling services. They move away from strong family support to a new culture with pressures to succeed. They are at risk of social isolation, and disadvantaged emotionally as they attempt to develop new coping skills, acculturate, and integrate into American society. Furthermore, their transnational existence (i.e., ties to the host country and country of origin) may overwhelmingly distress their psychological well-being. For example, many Kenyan immigrants may have been directly or relationally affected by trauma-related experiences relative to recurring inter-ethnic violence, wherein between 1992 and 2008 it is estimated that 4,000 people were killed and more than 1.6 million displaced. As another example, in 1998, the U.S. embassy bomb attack by Al-Qaeda terrorist group killed more than 200 people and many were injured. Sporadic terrorist attacks have been reported (e.g., Westgate Mall in 2013) that traumatize many families. In 2012, more than 400 were killed in interethnic violence (Wepundi et al., 2012).

It is unclear whether Kenyan immigrants recognize the need for psychological help. The Ndatei (2001) study found Kenyans as overly exposed to the medical-biological model of treatment for mental health concerns. As stated above, treatment was not easily available and affordable to this populace. It is not clear to what extent Kenyan immigrants in the United States are knowledgeable of the availability of counseling services and whether they would benefit from such services. Due to the fact that mental illness is severely stigmatized among Kenyans, their traditional conceptualization of mental health treatment could have important implications for their overall mental health.
and well-being, especially for those most in need of counseling services (Ndetei, 2001).

To summarize, there is a dearth of information regarding how help-seeking attitudes toward professional mental health services correlates with spirituality among Kenyan immigrants. While the Ndetei (2001) study provided a comprehensive overview of the advancement of mental health service delivery, there is a lack of research addressing how Kenyans perceive the need or benefits of seeking psychotherapy. Empirical data that informs and clarifies how Kenyan immigrants in the United States address and cope with their mental health concerns is needed. Furthermore, in the event of seeking professional counseling, it is not known how spiritual well-being influences Kenyan immigrants’ conceptualization of mental health and if adherence to religious beliefs influences their willingness to seek professional counseling.

There is paucity of empirical studies that focus on the relationship between demographic characteristics, spiritual well-being, and help-seeking attitudes of Kenyan immigrants in the United States. As noted earlier, within their culture, mental illness is profoundly associated with discrimination, shame, and stigma. Idemudia (2003) argued that Africans who have received a Western education are more likely to seek psychological help. Arguably, it is assumed that Kenyan immigrants in United States have greater access to mental health counseling services. Currently, it is not known whether Kenyan immigrants are aware of existing counseling resources that could be beneficial to them. From this standpoint, there is a compelling reason to examine their help seeking attitudes toward professional counseling, including how elements of spirituality and well-being interact with seeking professional psychological help.
Purpose of the Study

The primary purpose of this study is to describe the attitudes toward seeking professional psychological help among Kenyan immigrants living in the United States. Research in mental health is needed to provide culturally responsive programs that resonate with the values and unique experiences of the culturally defined populations to adequately meet their needs. For instance, the American Counseling Association requires “Counselors recognize that culture affects the manner in which clients’ problems are defined and experienced. Clients’ socioeconomic and cultural experiences are considered when diagnosing mental disorders” (Standard E.5b). A secondary purpose of this study, therefore, is to examine the relationships among attitudes toward seeking professional psychological help among Kenyan immigrants, various demographic characteristics, and spiritual well-being, which is an integral concept within their culture.

The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) (Fisher & Turner, 1970) will be utilized for this quantitative inquiry to measure attitudes toward seeking professional psychological help. The four factors in this scale are: (1) Recognition of Personal Need for Psychological Help, (2) Stigma Tolerance Associated with Psychological Help, (3) Interpersonal Openness Regarding One’s Problems, and (4) Confidence in Mental-Health Professional. The Spiritual Well Being Scale (Paloutzian & Ellison, 1991) will be utilized to assess levels of spiritual well-being. Demographic variables to be assessed in the study include age, gender, marital status, income, length of stay in the United States, and level of education.

Research Questions and Hypotheses

Based on the purpose of this study, the questions and associated hypotheses that
guide this quantitative research are as follows:

1. What is the relationship between demographic variables (i.e., gender, education, and marital status) and attitudes toward seeking professional counseling for Kenyan immigrants in the United States?

**Hypothesis 1:** There is a statistically significant relationship between gender, education, and marital status and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States.

1. What is the relationship between spiritual well-being, level of acculturation, and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States?

**Hypothesis 2:** There is a statistically significant relationship between spiritual well-being, level of acculturation, and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States.

**Theoretical Framework**

Serdarevic and Chronister (2005) outlined the benefits of an ecological theoretical framework for conducting psychological research with immigrant populations. In this dissertation, I propose to utilize Bronfenbrenner’s (1979) ecological framework for conceptualizing the strengths, supports, and risk factors of Kenyan immigrants in the United States. This framework is favorable for the purposes of this study for several reasons. First, it incorporates various components of culture in an integrated way that allows for a bi-directional exchange between an individual and different levels of his or her ecology over time. Bi-directionality is important in immigrant research due to its emphasis on culture of origin, as well as the exchange between the individual immigrant
and the host society (Serdarevic & Chronister, 2005). A second benefit of the proposed framework is its emphasis on acculturation as a complex, ever-changing process, which will allow the researcher to capture the richness of immigrant experiences. The framework has been used in interdisciplinary and international research to describe acculturation processes and ecological factors that lead to positive and negative mental health outcomes (Serdarevic & Chronister, 2005).

Beyond the benefits just described, Bronfenbrenner’s (1979) ecological framework is preferred for this study as it provides: (a) a visual representation of how different individual and contextual variables influence immigrant development, (b) a framework for examining multiple individual and contextual factors affecting immigrants’ acculturative adjustment and mental health, (c) a focus on immigrants’ mental health outcomes over time, not only immediately following migrating, and (d) the reciprocal impact of larger social contexts on individual immigrants, including their families, communities, and host societies (Serdarevic & Chronister, 2005).

Bronfenbrenner’s (1979) ecological framework suggests that individuals are embedded in multiple ecological contexts, which exert influence on individual development. A theoretical conceptualization of the role of context in immigration process is presented in Figure 1 and explained under five levels of ecology that comprise the ecological framework as follows:

1. The Microsystem, which consists of individuals and communities with whom the individual comes into direct contact which recognizes that people and communities at this level exert a more direct and frequent influence on individual development.
2. The Mesosystem, which includes the type and quality of relationships among microsystems, which does not include the individual.

3. The Exosystem, which explains the interconnections between one or more settings in which the individual is not directly involved such as in the public policy and government activities.

4. The Macrosystem, which represents our own values, cultural beliefs and norms, social structures, gender-role socialization, race relations and global resources. This includes beliefs about immigrants and the prejudices, racism and xenophobia toward immigrants that may result at the micro-, meso-, and exo-systemic levels.

5. The Chronosystem, which represents the development of interconnections among individuals and their environments over time (Bronfenbrenner, 1979).

![Bronfenbrenner’s Bioecological Model of Human Development](image)

*Figure 1. Bronfenbrenner’s biological model of human development.*
This study also adapted salient aspects of Myers, Sweeney, and Witmer’s (2000) holistic model of wellness and prevention conceptual framework to consider elements of spiritual well-being. As noted in this study, immigration process presents unique psychological challenges that impact the overall mental health and well-being of Kenyan immigrants. It is also clear that previous research indicated that these psychological challenges may negatively impact overall psychological well-being. The holistic model utilizes a paradigm of wellness as an alternative to the traditional illness-based medical model for treatment of mental and physical disorders. The holistic model defines spirituality as “an awareness of a being or force that transcends the material aspects of life and gives a deep sense of wholeness or connectedness to the universe” (Myers et al., 2000, p. 252).

Conversely, religiosity refers to institutional beliefs and behaviors and is broader than spirituality. The root word for spirit comes from *spiritus*, which means breath, courage, vigor, or life, and “is concerned with a person’s search for meaning, purpose, and value in life” (Wiggins-Frame, 2003, p. 2). Spirituality is integral to the Kenyan culture and worldview and is crucial as a source of coping with distressing situations and psychological challenges.

**The Significance of the Study**

Counselors are required to promote welfare of the client. Specifically, the American Counseling Association (2014) requires that, “Counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse population” (ACA, 2014, C.2.a. p. 8). The American Counseling Association code of ethics commit to “honoring diversity and
embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts” (p. 3). This study attempts to sensitize counselors to issues germane to Kenyan immigrants. As mentioned, there is a dearth of literature focusing on unique minority groups of African descent living in the United States. This study seeks to shed light on help-seeking attitudes among Kenyan immigrants living in the United States. The results of this study may be of value to practitioners and policy makers, and provide a broad overview of how Kenyan immigrants conceptualize mental health care and professional intervention. Such information targeting special populations is lacking in mental health literature. The study will serve toward filling this gap and may create discussion among Kenyan immigrants in the United States toward de-stigmatization of mental disorders and the mentally ill persons. As the U.S. population continues to become more ethnically diverse, it is incumbent upon mental health practitioners to be competent in working with immigrant populations.

Another significant aspect of this study is its potential contribution toward further studies in this area to explain Kenyan immigrants’ current understanding and perception of mental disorders, and how this influences their acculturation and coping styles. Further, it will serve to educate supervisors, therapists, and educators within the counseling profession on how to create culturally responsive programs and curricula that operate within the existing cultural values of Kenyan immigrants who experience mental health challenges. The American Psychiatric Association’s (2013) Diagnostic and Statistical Manual of Mental Disorders DSM-5 recognized the importance of understanding the cultural context of illness experience from a race and ethnicity
perspective for professionals who work with immigrants and ethnic minorities taking into consideration: (a) the cultural identity of the individual, (b) cultural conceptualization of distress, (c) psychosocial stressors and cultural features of vulnerability and resilience, cultural features of relationship between individual and the clinician, (d) overall cultural assessment. This study may add to the body of knowledge informing how spiritual well-being interacts with attitudes toward seeking professional counseling among Kenyan immigrants.

Definition of Terms

This section defines several key terms used in the current study. They include concepts such as:

*Attitudes Toward Counseling:* Overall outlook of an individual towards receiving mental health interventions as measured by the Attitude Toward Seeking Professional Help Scale (Fischer & Turner, 1970).

*Collectivist:* “Societies that stress ‘we’ consciousness, collective identity, emotional dependence, group solidarity, sharing, duties and obligations, need for stable and predetermined friendships, group decision, and particularism” (Hofstede, 1980). This concept is valued among African cultures.

*Culture:* Membership in a socially constructed way of living that incorporates collective values, beliefs, norms, boundaries, and lifestyles that are created with others who share similar worldviews comprising biological, psychosocial, historical, psychological, and other factors (American Counseling Association, 2014).

*Help-seeking:* “Behavior of actively seeking help from other people” as in informal (i.e., family and friends) or formal (professional counselors, psychologists,
psychiatrists) (Rickwood, et al., 2005, p. 4).

**Immigrants:** Foreign-born individuals who leave their countries on a voluntary basis in search of better opportunities and upward mobility. This study therefore focuses on Kenyan population living in the United States for any reason.

**Individualist:** Societies that emphasize ‘I’ consciousness, autonomy, emotional independence, individual initiative, right to privacy, pleasure seeking, financial security, need for specific friendship, and universalism (Hofstede, 1980).

**Mental Health:** “The successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and ability to adapt to change and to cope with adversity” (Satcher, 2000, p. 6).

**Professional Counseling:** “A professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (American Counseling Association, 2014, p. 20).

**Religiosity:** “Organized system of beliefs, practices, rituals, and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and (b) to foster an understanding of one’s relationship and responsibility to others in living together in a community” (Koenig, McCullough, & Larson, 2001, p. 18).

**Spirituality:** ASERVIC (1995) described spirituality as: “The animating force in life, represented by such images as breath, wind, vigor, and courage. Spirituality is the fusion and drawing out of spirit in one’s life. It is experienced as an active and passive process. Spirituality also is described as a capacity and tendency that is innate and unique to all persons. This spiritual tendency moves the individual towards knowledge, love,
meaning, hope, transcendence, connectedness, and compassion. Spirituality includes one’s capacity for creativity, growth, and the development of a values system. Spirituality encompasses the religious, spiritual, and transpersonal” (p. 30).

*Spiritual Well-Being:* Satisfaction with one’s relationship with God, with one’s sense of meaning and purpose in life and this concept will be examined as operationalized by the Spiritual Well-Being Scale (SWBS) (Ellison, 1983).

*Stigma:* According to the World Health Organization, “stigma results from a process whereby certain individuals and groups are unjustifiably rendered shameful excluded and discriminated against. However, stigmatizing is a common human characteristic, it is pervasive and subtle in its effects, and it is difficult to counteract without clear and conscious strategies” (WHO, 2002, p. 9).

*Ubuntu:* Has origins of Abantu (people) of Africa. It is a “Bantu ontological noun describing what it means to be a member of humankind, ‘personhood’ or ‘humanness’” (Mnyandu, 1997, p. 77).

*Worldview:* “A particular philosophy of life or conception of the world held by an individual or a group” (Funk, 2001, p. 1).

**Summary**

This study contains five chapters. Chapter I provided the background of the study, its purpose, research questions, significance, and definition of terms. Chapter II includes a review of the theoretical perspective that frames this study, and summarizes literature in the social sciences and psychology on the nature of spiritual well-being and help-seeking attitudes toward professional counseling services among Kenyan immigrants in the United States. Additionally, the chapter documents the historical, social, and cultural
contextual perspectives of sub-Saharan Africans and Kenyan immigrants living in the United States. Chapter III restates the study’s research questions and describes the methodology used to conduct the study. Chapter IV presents the results of this methodology, while Chapter V discusses these results within the context of existing literature, as well as implications for future research and practice.
CHAPTER II
REVIEW OF LITERATURE

There is a dearth of literature that examines attitudes toward use of mental health services among special populations, especially African immigrants living in the United States. This study examined help-seeking attitudes among Kenyan immigrants living in the United States, and the relationship of those attitudes to various demographic characteristics and spiritual well-being. This chapter provides a review of literature relevant to the study. The following topics are discussed: (a) Kenyan immigrants in the United States; (b) the historical, socioeconomic, and cultural contexts from which Kenyans immigrate; (c) mental health concerns of Kenyan immigrants living in the United States; (d) perceived barriers to care; (e) attitudes toward seeking professional counseling; (f) coping and spiritual well-being; and (g) the contrast of Afrocentric and Western thought.

Kenyan Immigrants in the United States

According to the 2008-2012 American Community Survey (ACS), nearly 40 million, or 4% of the total U.S. population is foreign-born. About 1.6 million of these foreign-born residents are from Africa. The largest group is made up of people from West Africa, representing 36% of the 1 million Africans. The second largest group, East Africans, increased from 12% in 1980 to 29% by 2012. Kenya, an East African country, represents 6% of the 1 million Africans currently residing in the United States, and is listed fifth among East African countries with immigrants in the United States, after Nigeria (14%), Ethiopia (10%), Egypt (9%), and Ghana (8%) (American Community Survey, 2014).
Inman and Tummala-Narra (2010) defined immigrants as, “foreign-born individuals who leave their countries on a voluntary basis” (as cited in Cornish et al., 2010, p. 117). According to Inman and Tummala-Narra (2010), immigrants “Typically… leave their countries in search of better economic opportunities and upward mobility” (as cited in Cornish et al., 2010, p. 117). Several laws passed during the years between 1965 and 1990 have contributed to the increase in numbers and shift in national origins of U.S. immigrants (Kent, 2007). The 1965 Immigration and Nationality Act facilitated the current wave of immigrants, and fundamentally altered the racial and ethnic make-up of the United States. Also known as the Hart-Cellar Act, this law loosened restrictions on immigration based on geography, which had, in effect, restricted immigration opportunities for non-whites (Department of Homeland Security, 2007, as cited in Kent, 2007).

Another law, the Refugee Act of 1976 fundamentally changed refugee policy to conform to United Nation protocol on refugees, and provided for 50,000 visas for refugees annually. This increased the number of immigrants from the horn of Africa especially Somalia, Ethiopia, and Eritrea where civil and international conflicts were displacing thousands of people (Department of Homeland Security, 2007, as cited in Kent, 2007). Then, in 1986, the Immigration Reform and Control Act (IRCA) made it possible for undocumented immigrants living in the United States to apply for legal status. Finally, the 1990 Immigration Act increased the number of immigrants admitted on the basis of skills for U.S. jobs. It also introduced the Diversity Visa Program (DV) to admit immigrants from countries not well represented among the U.S. immigrant
population. Between 1998 and 2006, sub-Saharan Africans received 27% of the diversity visas awarded by the United States (Kent, 2007).

It should be noted that the long-standing relationship between Kenya and the United States has exposed many Kenyans to different facets of American culture, thus contributing to increased Kenyan immigration to the United States. Kenyans continue to migrate to the United States to seek better opportunities and to succeed in life. Existing favorable immigration factors such as the annual U.S. Diversified Visa Lottery (DV-Lottery) allow for permanent residency. In the DV-2013 Green Card lottery, Kenya had the ninth highest number of winners in the world, and was fifth in Africa, with 4,410 total winners, behind Nigeria (6,218), Ghana (5,105), Egypt (5,015), and Ethiopia (4,910) (Department of State, 2012).

Overall, the provision of H1-B visas, which permit upwardly mobile professionals to live and work in the United States, has caused an unprecedented influx of Kenyans studying in American universities or living in the country over the last two decades. Kenyans obtaining legal permanent resident (LPR) status increased by approximately 30% from 3,199 in 2002, to 9,880 in 2009. While this number declined to 7,762 in 2011, there has nevertheless been sustained immigration by Kenyans into the United States (United States Department of Homeland Security Yearbook, 2012).

Previous studies have focused on global forces leading to the significant increase in the number of African immigrants in the United States (Takougang, 2003). There are few studies on African immigrants, however, that focus on structural obstacles, social and economic integration (Fennelly & Shandy, 2006), transnationalism (Owusu, 2003), acculturation, or suicide attitudes (Eshun, 2006). Some existing studies do focus on the
mental health of West African immigrant populations (Thomas, 2010), Nigerian immigrants’ mental health (e.g., Achikam, 2009; Maleche, Landrum, & Symes, 2010; Okafor, 2003), alienation and stress among Black immigrants living in the United States (Nwadiora, 1997), and therapies with African immigrant families (Nwadiora, 1996). Both Kamya (1997) and Turner (1994) argued that limited attention has been given to the study of immigrants of African descent; however, none of these studies have explored Kenyan immigrants specifically.

To date, little is known about the mental health of Kenyan immigrants living in the United States. Kenyan immigrants experience unique challenges and stressors, which may lead to psychological and emotional problems requiring professional mental health intervention. Kagawa-Singer and Chung (2002) and Akutsu (1997) asserted that Kenyans, who immigrate to the United States for a variety of reasons, including seeking advanced education, lucrative economic opportunity, escaping religious or ethnic persecution, fleeing civil strife, or joining relatives in America, often lack knowledge of or exposure to Western mental health system. These immigrants may also have misconceptions about professional counseling that deter them from accessing mental health services.

When arriving to the United States, Kenyan immigrants may experience poor reception in the host country, and this is likely to contribute to or exacerbate mental health concerns that may need to be addressed. Kenyans emigrate from a country that has underdeveloped professional mental health services that are heavily reliant on a medical model of treating and addressing mental health concerns. Conversely, the Western mental health profession originates from an ideological milieu of individualism that while
promoting competence, autonomy, and resistance to stress, may be perceived as contrary to traditional Kenyan values (Ahuvia, 2001; Triandis, 2000). The Western empiricist view assumes a universal explanation of origin, process, and manifestation of mental disorders. These values may be incompatible with Afrocentric cultural values that emphasize communalism (e.g., importance of human relationships and interrelatedness of people), collectivism (e.g., placing priority on group goals instead of individual and personal ones), unity, cooperation, harmony, spirituality, balance, creativity, and authenticity (Constantine, Gainor, Ahluwalia, & Berkel, 2003).

**Historical, Socioeconomic, and Cultural Contexts From Which Kenyans Immigrate**

According to Ross-Sheriff (1995), sub-Saharan African immigrants share some similarities but cannot be lumped together due to distinctions of culture, language, religion, and traditions. Balakrishnan and Wu (1992) concurred that researchers often ignore or lump Africans and Caribbean immigrants together into one analytical category as “Blacks.” Since Kenyans are often homogenously grouped with Black/African Americans, Haitians, Nigerians, or generalized as Africans, it is imperative to provide their unique experiences in order to have a better perspective of the background from which Kenyans living in the United States developed. The following sections discuss the historical, socioeconomic, and cultural contexts from which Kenyans immigrate.

**Historical Context**

It is imperative for mental health professionals to consider the historical context of Kenyan immigrants’ experiences, and tailor diagnostic and treatment systems accordingly. Geographically, Kenya lies almost exactly astride the equator and is strategically located in the center of Africa’s eastern region, south of the Horn of Africa,
along the western Indian Ocean. It borders South Sudan and Ethiopia to the north, Somalia to the east, Uganda to the west, Tanzania to the south, and Indian Ocean to the Southeast. Chau (2010) asserted that ancestors of modern Kenya’s population began arriving in the region around 2000 B.C., when Cushitic-speaking pastoralists migrated south from the Ethiopian highlands. Between 500 B.C. and 500 A.D., Nilotic speakers, who now live in the Nyanza and Rift Valley region, arrived along with Bantu-speaking peoples who live in the coastal, eastern, central, and western region, and now make up three-quarters of Kenya’s population (Chau, 2010).

Recent archaeological discoveries featured in Chinese Archaeology (2013) revealed that Kenya’s civilization may have coexisted or interacted with Arabic and European civilizations. This was evidenced by discoveries of Arabic and European pottery, as well as Chinese ceramic found in ancient Malindi villages on the Kenyan coast. These discoveries seemed to indicate that Kenya’s civilization thrived between the 12th and 14th centuries. A dated five-sided brass coin and a shell were also discovered. Royalty of the Ming dynasty were the only people to use these items in trade. Chinese archaeologists believe famous Chinese trader and admiral Zheng brought the items as a gift (Chinese Archaeology, 2013).

The discoveries described in Chinese Archaeology (2013) dispel John Wilson’s 19th century negative depiction of Africa as a “dark continent,” published in his classic work, “Africa, The Dark Continent, Western Africa: Its History, Condition, and Prospects. The treasures described above reveal that Kenya had a rich cultural history, robust trade links, and ethnically diverse population prior to its colonization by the British Empire.
Politically, Arab traders, under the leadership of Sultan of Oman, reigned in the Kenyan coast where slave trade flourished as early as the 10th century. The Portuguese fought for the coast during the 15th and 16th centuries. During this time, the Kenyan people had established systems of self-governance, religious rituals, and cultural practices for treating illness. By the second half of the 19th century, pre-colonial Kenya had increasing contact with the outside world. Africa's largely untapped wealth attracted scores of Europeans. The British arrived in the 1880s, and the Imperial British East Africa Company (IBEAC), later known as Kenya, was established. This paved the way for the subsequent establishment of the British administration in 1888, and at the 1888 Berlin Conference, Africa was partitioned and colonized by various European nations (Ogot, 1976).

Kenya became a British colony in 1895 with administrators, settlers, traders, and missionaries pouring into Kenya bringing with them, “…a new and strange way of life with sometimes incomprehensible demands and ideas” (Ogot, 1976, p. 136). Sir William MacKinnon led in this effort, establishing trading centers and bringing together more than 40 warring African tribes for control and taxation. It became increasingly challenging for the Kenyan people to adjust themselves to the problems and ideas posed by the new system of government, economy, religion, and education (Ogot, 1976). There were violent uprisings against the British rule. In the liberation struggles, thousands were killed, dehumanized, brutalized, and had property seized.

Prior to Kenya's independence in 1963, thousands of Mau Mau fighters were arrested and incarcerated in concentration camps where many underwent torture and inhuman treatment. Atwoli, Kathuku, and Ndetei (2006) conducted a study of the Mau
Mau survivors in Kenya and found that 65.7% of 181 camp survivors sampled had posttraumatic stress disorder (PTSD) and other psychiatric morbidity. The study further revealed that survivors avoided discussing the event and became sick during Independence Day celebrations (Atwoli et al., 2006). In Britain’s Gulag: The British End of the Empire in Kenya, Elkins (2006) narrated the brutal ordeal of thousands who were detained and taken through the “pipeline,” a brutal network of detention camps designed to breakdown the resistance of oath-taking fighters against British rule. The pipeline sought to destroy the will of the fighters, after which they would confess, undergo rehabilitation, and be absorbed back in the community (Elkins, 2006).

A publication distributed by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2013) suggests that individuals who suffer generational trauma may internalize views of their oppressors, and perpetuate a cycle of self-hatred that manifests itself in negative behaviors. Furthermore, emotions such as anger, hatred, and aggression may also be inflicted on members of one’s group (SAMHSA, 2013). To date, it is not clear how the historical traumas suffered by the Kenyan population has been expressed or otherwise resolved, nor is it known how such trauma continues to affect the families and communities that experienced these injustices.

In his book, The River Between, Ngugi wa Thiong’o (1969), a prolific Kenyan novelist, portrayed the conflict between Western Christian missionary and African indigenous worldviews. The novel also characterized the resistance and change from a traditional lifestyle to a lifestyle of modernity and Christianity. The Elkins (2005) narrative observed that the British occupation of Kenya led to a colonial transformation that included implementation of Western values. The British settlers believed they had a
“civilizing mission” and a moral obligation to redeem the “backward heathens” of the world (p. 5). Therefore, they were going to enlighten the Dark Continent by transforming the so-called “natives” into progressive citizens, ready to take their place in the modern world (Elkins, 2005). The paternalistic authority of the British colonial government led to systematic condemnation of the “heathenism” of African religious and cultural practices by promoting “Victorian aspirations,” the preaching of Christian values, and through commerce they established mission stations, which included churches, schools, and medical clinic centers through which, African socio-cultural worldviews and religious foundations were repressed and Western values were propagated. Thus, while colonization and Western missionaries provided the “gift” of literacy to Kenyans, they also served to deconstruct and undermine the cultural values and belief systems of the Kenyan people (Elkins, 2005).

Pieterse, Howitt, and Naidoo (2011) warned that aspects of colonialism that may be superficially viewed as benign were, in actuality, malignant in nature. One of the criticisms of colonization was its disregard for the basic collectivism of the African personality with family, community, society, and culture. The colonizing power’s strategy was aimed at removing people of African descent from those psychological and cultural worldviews that represented an important part of their identity. Similarly, Graham (2006) explained the Maat viewpoint, which embodied the Afrocentric worldview of understanding the human condition under three guiding principles, (a) the spiritual nature of human beings, (b) the interconnectedness of all things, and (c) oneness in mind, body, and spirit, was systematically dismantled.
There is paucity of information regarding the psychological impact of the colonizing power on issues of self-identity, deconstruction of cultural beliefs and conceptualization of mental health, and how Kenyan immigrants embrace Western views within the context of utilization of psychological help. The *Maat* philosophy contradicts Western notions of individualism, which extends to individual psychological processes (Graham, 2006). Due to conflicting worldviews, there could be a common belief that a Kenyan immigrant may be reluctant to seek help from a counselor that espouse Western views of mental health. Counselors working with people of African descent, particularly in relation to the experience of oppression and racial trauma, are encouraged to incorporate an Afrocentric approach that emphasizes spirituality and interconnectivity into their counseling practice (Graham, 2005). The relationship between spiritual well-being and use of counseling services is discussed later in this chapter.

**Socioeconomic Context**

As mentioned, several factors have contributed to the influx of Kenyans who immigrate into the United States. Goldsmith (1982) and Hornsby (2012) asserted that at the time of independence in 1963, the first government of Kenya was pro-west and pro-capitalist, and less aligned to China and Union of Soviet Socialist Republics (USSR). The formation of the new government created an insatiable demand for higher education. There was growing need to fill up the ranks of the civil service, and Kenya lacked sufficient numbers of graduates to fill the vacancies that would be vacated by departing British officials. Additionally, the 1958 and 1959 efforts of the Kennedy Foundation along with various educational agencies such as the Institute for International Education (IIE), the Council for Educational Co-operation with Africa (CECA), and the Kenya
Educational Foundation (KEF) coalesced into the Kennedy Airlift, which established substantial scholarships and travel assistance programs for Kenyans to attend universities in the United States. Between 1960 and 1965, more than 1,000 Kenyan students benefited from the program (Goldsworth, 1982; Hornsby, 2012).

The decade between 1990 and 2000 saw particularly high numbers of Kenyan immigrations into the United States. This decade coincided with an economic crisis that struck a number of less developed countries (LDCs) in Africa. According to Damiano and Sen (2004), Kenya’s economic growth had declined due to a rise in petroleum prices, and a sharp decline in prices and demand for the country’s key export agricultural products like coffee and tea. Furthermore, the subsequent collapse of the East African Community (EAC) denied Kenyan exporters preferential access to free markets. Kenya experienced high population growth, drought, famine, rapid urbanization, widespread poverty, increased debt, and disease (Damiano & Sen, 2004). These factors may have impacted on Kenyans’ social and mental well-being.

The World Bank (WB) and International Monetary Fund (IMF) introduced and implemented the Structural Adjustment Programs (SAP), which resulted in massive laying-off of workers, cost-sharing for social services, labor unrest, reduced minimum wage, sporadic student unrest, and political instability. The economic reforms in accordance with the SAP contributed to Kenyans leaving the country to seek better opportunities in United States and other countries. The breakdown of the educational system in the 1990s, especially with the population increase, the introduction of a double intake system in colleges, lack of educational facilities, and rapid disruptions in the educational system as a result of frequent teachers’ strikes also contributed to Kenyans’
need to seek educational pursuits in the United States (Damiano & Sen, 2004).

Furthermore, according to the Kenya National Focal Point on Small Arms and Light Weapons survey (2012), 48% of Kenyans feel insecure due to recurrent ethnic violence. More than 4,000 people were killed between 1992 and 2008, and 1.6 million displaced, which also contributes to current immigration trends (Wepundi et al., 2012).

Cultural Context

Culturally, Kenya is linguistically diverse, with 42 languages spoken in the country. Most Kenyans are multilingual, speaking their own ethnic language (e.g., Gikuyu, Giriama, Gusii, Luhyia, Luo, Kalenjin), English, and Kiswahili. English is the official language of instruction, and Kiswahili is the national language spoken by almost every Kenyan. Urban young people also speak Sheng, a hybrid language composed of English interspersed with other ethnic languages.

Traditional African beliefs play a significant role in the lives of Kenyans, in spite of adapting to modern Western values. For most Kenyans, traditional values are considered imperative to maintaining kinship ties. Traditional belief systems and practices influence many cultural practices such as child naming, rites of passage, and burial, but vary from community to community. Belief systems may also vary somewhat between urban and rural areas; for example, superstitious beliefs are common, but especially in the rural areas.

Cultural practices have a significant influence on perceptions of mental health in Kenya, especially within the context of colonization. Carson (1997) and Mpofu (2013) investigated how ideologies developed during colonization influence the delivery of mental health care to Africans. Many of the anthropological, psychological, and
sociological theories that were developed during the mid-nineteenth century had a pejorative outlook on the African person’s mental and emotional capabilities. For instance, Carothers (1953) in the seminal work *The African Mind in Health and Disease* claimed Africans exhibit a violent impulsivity and immaturity, which prevents complexity and integration in the emotional life therefore justifying use of drugs in treating mental illness. While Carothers’s work was written more than 70 years ago, it has a lasting influence on how Africans are viewed and treated within the mental health community (Carson, 1997; Mpofu, 2013).

In general, there is a vast difference between how mental health is conceptualized and treated in Western and African worldviews. From the African worldview, mental health is often explained in dichotomous either-or extremes—either possessed or not possessed. There is no room for a continuum of wellness. Traditionally, the popular African shaman or medicine man provided a holistic approach (e.g., spiritually, physically, and psychologically) to treatment. The shaman treated or resolved problems “once-and-for-all,” using divination or medicine depending on the identified need. According to Appiah (2012), “Treatment…ranges from incantations to fasting and bleedings but is most often an herbal concoction imbued with metaphysical significance” (p. 831). In addition to treatment provided by the shaman, the wisdom of the elders was also sought for guidance in resolving interpersonal concerns.

The introduction of the Western model of medicine, which included specialists for each presenting problem, disorganized the traditional African method of treatment. For example, in the Western model, there are religious leaders to address spiritual needs, medical doctors for physical ailments, and highly trained therapists to address
psychological and mental health problems. As explained above, this is different from the traditional African model, wherein the shaman provided all forms of care. I argue that anyone visiting a generalist shaman was not likely to be stigmatized because people in the village may have not necessarily known the client’s presenting problem. The medicine man held an acclaimed position in the society and was believed to possess inherent powers to heal multiple ailments. Conversely, under the Western model of seeking treatment, others are likely to know that a client visiting a mental health specialist or therapist over multiple visits needs psychological help, thus perpetuating stigma and alienation.

**Mental Health Concerns of Kenyan Immigrants Living in the United States**

Few researchers have documented mental health problems experienced by African immigrants. Nwadiora (1996) found that many African families residing in Euro American culture undergo a unique psycho-cultural encounter resulting in stress. Specifically, adjustment difficulties arising from their multiple identities of being Black and African, and adjustment to a predominantly White culture may be stressful. According to Nwadiora (1996), another source of stress for many Africans is cultural differences in family norms. For instance, the challenges to the patriarchal family structure can complicate husband and wife relationships, leading to discord in the family unit (Nwadiora, 1996).

Among Kenyans immigrants in the United States, there are several specific concerns that have an influence on mental health. These concerns include: (a) traditional male norms, (b) domestic violence, (c) challenges in parenting, (d) problems in the
academic success of children, and (e) employment and skills transferability, and are discussed in the paragraphs below.

**Traditional Male Norms**

Muriithi (2013) discussed pertinent psychosocial problems affecting Kenyans in the United States following a series of legal, suicide, and homicide episodes. In one interview, a Georgia Bureau of Investigations (GBI) Homicide Division Detective stated, “We find it bizarre that most homicide cases reported among the immigrant communities are involving Kenyans who are numerically outnumbered by many other nationals” (Muriithi, 2013). According to Odhiambo (2013), the mental health problems in the Kenyan community are attributed to such problems as: (a) Kenyan men (who suffer the most mental health concerns) fail to express personal problems, but rather remain stoic for fear of breach of confidentiality; (b) Kenyan men lack adequate social support systems within the hectic lifestyle of the United States; and (c) Kenyan men feel intimidated by the fact that they do not have total control of their wives, as was the case for some back in Kenya (Muriithi, 2013, p. 1).

Hammond (2012) asserted that traditional masculine role norms tend to lessen help-seeking among men, therefore artificially lowering male depression rates. According to Hammond (2012), traditional masculine role norms prescribe emotion restriction and self-reliance as appropriate male stress responses (e.g., “Boys don’t cry” and “Take it like a man”). Kenyan masculinity emphasizes such self-assuring stoic statements, and men are figuratively depicted as the household “pillar of strength.” In the African context, a neglectful father in daily informal conversation may be reminded that every traditional house has a pole at its center supporting the roof and keeping the whole structure
together. Man is the “pole of the house,” and needs to live up to this expectation by his courage because “fear is the dress of women” (Dalfovo, 1991).

**Domestic Violence**

Immigration can provide abundant opportunity for African women to assert themselves and aspire to higher professional status; however, at times, this may threaten the husband’s sense of being the breadwinner, thereby impacting on the psychological well-being of the family system and increasing the potential for domestic violence (Nwadiora, 1996). Ting and Panchanadeswaran (2009) investigated African barriers to help-seeking among immigrant African women survivors of partner abuse. Their study revealed that African women experience a culture of gender inequality and acceptance of gender violence, self-blame, loyalty, concern for children, and lack of knowledge regarding abuse. Multiple homicides and partner abuse have been reported among Kenyan families in the United States, which raises questions about whether Kenyans are familiar with or willing to utilize available counseling services.

**Challenges in Parenting**

Morales and Hanson (2005) observed that socialization process for immigrants often includes a sort of role reversal, wherein children provide their parents with information about the ways of the new country. This becomes a burden when children serve as cultural and linguistic brokers. In this case, parents may have to surrender their power to their children in the acculturation process (Miller, 2011). Moreover, according to Bledsoe (2011), African immigrants in particular are faced with parenting challenges due to long-standing African disciplinary practices that are dissimilar to Western views of child discipline. When stripped of the ability to use traditional disciplinary practices,
African parents often feel stripped of their wider social and cultural contexts, and at a loss as to how to help their children succeed (Bledsoe, 2011). By mental health and international law, traditional measures that include corporal punishment may be regarded as abuse or as a breach of children’s human rights (Bledsoe, 2011).

Kabba (2002) noted that restrictive corporal punishment laws tie the hands of parents who are desperate to intervene to save their children from serious trouble. African parents are terrified of losing their children to criminal justice or foster care systems, or simply of “watching their children’s academic ambitions dissolve into apathy” (Arthur, 2008, p. 144). Most African immigrants, despite their efforts to achieve success, come to sense that irrespective of their origin or character, their Black skin color may preclude them from achieving full membership in a country that proclaims itself a democracy of equals. For an African family, armed with the tools used by their parents to raise them, once in America, those tools are rendered obsolete. The American concepts of parenting such as reinforcements and timeout are foreign and seem less effective (Kabba, 2008).

In addition to problems with child discipline, certain urban places, rife with drugs, crime, sexual licentiousness, rampant violence, and contempt for adult authority, present a most unpromising environment for successful childrearing (Bledsoe, 2011). African immigrants often blame Western media (e.g., T.V. movies, music, videos) for saturating their youth culture with images of violence, insubordination, and depravity. These may potentially undermine children’s respect for elders’ authority; lure them into drugs, truancy, and sexual licentiousness; and serve as breeding grounds for gangs (Bledsoe, 2011).
Problems in the Academic Success of Children

As aforementioned, Kenyans are often homogenously grouped with Black/African Americans, Haitians, Nigerians, or generalized as Africans due to their skin color. Researchers have reported teachers’ low academic expectations for minorities living in the United States due to racism and discrimination (Lashley, 2001; Mitchell, 2005). For instance, a Maryland State Department of Education (MSDE) taskforce reported that, “African American male youth have been branded violent, uneducated, uneducable, drug addicted, malevolent, deficient, defiant, recalcitrant, hostile, ungovernable, immoral, amoral” (Maryland State Department of Education, 2006, p. 3). Confounding this issue, Kenyan youth/students are likely to be lumped together with African American youth, and therefore denied the opportunity for support to unleash their full potential for success. Kenyan parents are likely to be stressed and disappointed if their children are racially discriminated against in school and if the efforts of their children for success are unsupported.

Furthermore, Mitchell (2005) argued that Caribbean immigrant students studying in the United States have a high dropout rate due to environmental issues associated with achievement difficulties that also are found among African American students in general. Some problems prevalent among minorities may include attending segregated schools, limited resources, violence, and administrators’ apathy. The researcher found that these problems contribute to reducing Caribbean students’ academic performance and persistence (Mitchell, 2005). Kenyan students also are likely to experience similar achievement difficulties that may discourage their educational achievement and social well-being.
Employment and Skills Transferability

Anderson and Winfield (2011) suggested that underemployment adversely affects psychological well-being, and has an impact on marital, family, and social relationships; depression; life satisfaction; and general affect. The struggle to financially succeed in the host country is a major source of psychological problems. Underemployment also adversely affects the psychological well-being of the family, which subsequently may lead to domestic disputes, child neglect, and abuse. Immigrants who work in semi-skilled jobs are likely to be overworked or underpaid. Likewise, some may be overqualified for the positions that they agree to take on for the purpose of making ends meet. Others may lack job searching and negotiation skills, thus perpetuating the problem of underemployment and psychological maladjustment (Anderson & Winfield, 2011).

Research focusing on the prevalence of underemployment is limited, although it has been found to be higher among minority groups with foreign-born concentrations (Anderson & Winfield, 2011). Slack and Jensen (2011) reported higher rates of underemployment among immigrants than natives. Many Kenyans who immigrate are highly skilled, but do not necessarily find employment in the host country that matches with their qualifications. Many Kenyans, therefore, work in two or three jobs in order to succeed and financially support their relatives in Kenya.

Perceived Barriers to Care

A better understanding of barriers that inhibit access and utilization of mental health treatment among immigrants may inform the design of clinical services and public health aimed at improving access and education efforts. Historically, most resource-scarce African nations do not allocate enough funding to the prevention and treatment of
mental health issues (Atwoli, 2011a). Ndetei (2001) asserted that for a long time, mental health has not been regarded as an important component of total health. This state of affairs has led to mental health being given a low priority in the provision of mental health services in Kenya. Similarly, Atwoli (2011b) observed that Kenya’s mental health is allocated meager resources and does not meet the Abuja Declaration of 2001, part of the African Union’s pledge to increase government funding for health to at least 15% of the national budget. Health expenditure on mental health remains abysmal at less than 0.5%, most of which goes to pay salaries and allowances of staff at Ministry of Health headquarters. This lack of adequate funding is most likely to stymie mental health prevention and treatment efforts.

Motjabai and colleagues (2010) examined data from the National Comorbidity Survey Replication (NCS-R), a representative survey of the U.S. general population, to investigate barriers to initiation and continuation of treatment among individuals with DSM-IV mood, anxiety, substance, impulse control, and childhood disorders. Respondents were asked about perceived need for treatment, structural barriers and attitudinal/evaluative barriers to initiation and continuation of treatment. Results indicated that attitudinal/evaluative factors were found to be much more important than structural barriers, both to initiating (97.4% v. 22.2%) and to continuing (81.9% v. 31.8%) of treatment. However, reasons for not seeking treatment varied with illness severity (Motjabai et al., 2010).

The Motjabai et al. (2010) study further revealed that low perceived need for treatment was a more common reason for not seeking treatment among individuals with more mild (57.0%) than moderate (39.3%) or severe (25.9%) disorders, whereas
structural and attitudinal/evaluative barriers were more common among respondents with more severe conditions (Motj-abai et al., 2010). Additionally, the desire to handle the problem on one’s own was the most common answer among respondents with perceived need, both for not seeking treatment (72%) and for dropping out of treatment (42%). Over 30% of respondents who dropped out of treatment cited an attitudinal/evaluative barrier, such as stigma, negative experience with providers, or perceived ineffectiveness of treatment, which shows low perceived treatment quality leads to treatment drop-out.

**Health Insurance Coverage and Affordability**

Lack of health insurance coverage is a barrier to accessing and seeking mental health services among minorities. It is argued that people without access to medical care often have no choice but to allow preventable conditions to escalate into serious conditions. For example, Holden and Xanthos (2009) found that African Americans experience mental health disadvantages when compared to European Americans due to financial barriers, barriers to help-seeking, and poor quality services. The Center for Disease Control (CDC) revealed that foreign-born adults were uninsured at 26% higher rates than their U.S. born counterparts. Likewise, immigrants were twice as likely as native-born adults to have no usual source of healthcare, and less likely to have spoken to a healthcare practitioner in the past year or ever (Segal, Elliot, & Mayadas, 2010).

Another study conducted by Saechao et al. (2012) examined stressors and barriers to using mental health services among six focus groups (i.e., Cambodians, Eastern European, Iranian, Iraqi, African, and Vietnamese) of first generation immigrants in California. This study revealed that the high cost or lack of affordable health insurance is one of the major impediments to accessing or seeking mental health treatment (Saechao
et al., 2012). Further studies focused on worldwide immigration policies, practices, and trends found that in the event that immigrants have good healthcare coverage, they may be less knowledgeable about the availability of programs and services (Segal et al., 2010).

**Cultural Beliefs and Stigma**

More action needs to be taken to combat or eliminate stigma and discrimination against people living with mental illness. For Kenyans, some of these actions include promoting laws, policies, and public education about mental health. As noted by the Kenyan Standard Newspaper Headline, “12 million Kenyans suffer mental disorders as harsh life pushes them over the cliff.” The report further indicated that there are many people on the street who have given up on life, but shun professional medical services available to them due to the stigma associated with mental problems (Kiarie, 2014). More needs to be known concerning how Kenyan immigrants conceptualize and seek help for their mental health problems. Stigma is associated with mental illness, and may hinder the utilization of psychological services among Kenyan immigrants. According to Fink and Tasman (1992), *stigma* refers to the marginalization and ostracism of individuals who are mentally ill. It can lead to delays in seeking treatment or concealment of one’s illness to avoid the negative labels associated with mental health needs. Stigma, together with lack of awareness or understanding of services, may all function as barriers to seeking mental health services for the Kenyan immigrant population (Fink & Tasman, 1992).

Social Identity Theory (SIT) by Overtone and Medina (2008) explains the construct of stigma under social identity, self-stigma, and structural stigma. The
researchers explained the social identity concept as use of social constructs to judge or label someone who is different or disfavored. According to Goffman (1963), societies evaluate people to determine if they fit the social norms. Stigmatized people form a virtual social identity when they become disfavored or dishonored in the eyes of society, and they become outcasts. Overton and Medina (2008) argued that mental illness is often viewed as a character of moral flaw. In self-stigma, people tend to judge themselves through an internal evaluation process as a result of messages received from societal norms, ultimately creating judgment toward themselves (Overton & Medina, 2008). Structural stigma is an external evaluation of a person that is based on societal norms, resulting in tangible barriers for people who have mental illness. Structural stigma impedes opportunities for people with mental illness in finding employment, adequate shelter, and treatment, and results in negative attitudes toward mental health professionals. The media is especially complicit in perpetuating structural stigma and the negative image of people with mental illness (Overton & Medina, 2008).

Nadeem and colleagues (2007) found that stigma-related concerns were significantly related to a lower desire for mental health treatment for immigrant women from ethnic minority groups. According to Johnstone (2001), “people suffering from mental illness and other mental health problems are among the most stigmatized, discriminated against, marginalized, and vulnerable members of our society” (p. 201). Kenyans emigrate from a country that continues to discriminate against people living with mental disorders. To illustrate, Kweyu (2012) noted that almost every Kenyan community has derogatory epithets reserved for people with mental illness, such as mwenda wazimu (Kiswahili), one possessed by evil spirits, mundu wa ngoma (Kikuyu),
which connotes spirit possession or who belongs to the spirit world, *omulalu* (Luhya), and *janeko* (Dholuo), which points to inbuilt prejudices against people living with mental illness (Kweyu, 2012). These negative inferences about individuals and families living with mental health problems perpetuate stigma and likely discourage Kenyans from seeking help.

In their study on mental health stigma, Shea and Yeh (2008) found similar barriers among Asian international and Asian American students, which included historical and cultural influences on coping with personal problems and a high level of social stigma attached to seeking psychological treatment for mental health concerns. Extra familial intervention such as seeking professional psychological help is often considered shameful and a violation of the family hierarchy (Shea & Yeh, 2008). The significance of shame and denial as barriers to help-seeking is highlighted among African Americans as such that they may decide not to seek mental health services or fail to participate once they have sought help (Holden & Xanthos, 2009). Similarly, like Asian Americans, Kenyan immigrants are likely left to deal with problems by themselves or seek informal helpers such as family, churches, physicians, elders, clan, or ethnic organizations. These studies support that health and social burdens are also likely to increase among Kenyan population in the United States due to social cultural stigma attached to having mental health conditions (Ellis, 2012).

**Attitudes Toward Seeking Professional Counseling**

Although there is burgeoning literature on immigrants examining the utilization of professional counseling services, less focus has been placed on African immigrants. Researchers have focused on attitudes among Asians (Ang, Lau, Tan, & Lim, 2007),
Latino populations (Garces, Scarinci, & Harrison, 2006), Afro-Caribbean immigrants (Ellis, 2005), and immigrant women (Yakushko & Chronister, 2005). Certain demographic variables such as education, religion (Fischer & Cohen, 1972), locus of control (Fischer & Turner, 1970) national origin (Dadfar & Friedlander, 1982; Todd & Shapira, 1974), self-concealment (Kelly & Achter, 1995), emotional openness (Komiya, Good, & Sherrod, 2000), perceived comfort and benefits of self-disclosure (Vogel & Wester, 2003), level of acculturation, individualism, social-network orientation (Tata & Leong, 1994), cultural commitment (Price & McNeill, 1992), cultural values (Kim, 2007; Kim & Omizo, 2003), alienation, and racial identity (Delphin & Rollock, 1995) have been linked with attitudes toward seeking psychological help.

The World Health Organization (WHO) constitution states: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity” (WHO, 1946, p. 1). Despite the fact that mental health is an integral component of health, many people shun seeking mental health services. The report of Surgeon General Satcher (2000) emphasized among other general considerations that: (a) mental health is fundamental to health, (b) mental disorders are real health conditions, (c) culture consideration in treatment is important, (d) the efficacy of mental health treatments, and (e) the existence of a range of treatments for most mental health disorders. The report further revealed that 1 in 5 Americans has a mental health disorder in any one year and 15 % of the adult population use some form of mental health service during the year. Mental disorders collectively account for more than 15% of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer (Satcher, 2000).
Despite these basic facts, studies reveal that minorities in the United States (e.g., American Indians, Asian Americans, African Americans, Latino/Hispanic Americans) are likely to underutilize traditional mental health services (Cheung & Snowden, 1990; Kearney, Draper, & Baron, 2005; Wang & Kim, 2010). Other researchers suggested that minority group individuals underutilize and prematurely terminate counseling due to the biased nature of the services (Kearney et al., 2005) that are frequently antagonistic to the life experiences of the minority clients (Cokley, 2006), and rife with incompetent mental health professionals due to biased training systems (Mio, 2005; Utsey, Grange, & Allyne, 2006). This calls for further examination of the level of confidence in mental health professional among Kenyan immigrants.

As aforementioned, Black and Jackson (2005) found that a tremendous emotional toll is exacted when people leave their families, and this toll is more pronounced with immigrants. The ecological model articulated by Urie Bronfenbrenner (1989) suggested that individuals are embedded in multiple ecological contexts that exert influence on individual development. Immigrants have a sense of loss of the actual family bond and social dislocation, and experience difficulties of coping and assimilating in the new sometime hostile environment, which often leads to mental health disorders. For example, Laurens et al. (2008) found that there is increased incidence of schizophrenia and elevated incidence of psychotic symptoms among adults of African Caribbean ethnic immigrants in the United Kingdom.

Similarly, Weiser et al. (2007) found that Ethiopian immigrants to Israel, who were culturally and distinctly different in appearance as compared to former Soviet Union immigrants and host population, were at a higher risk for schizophrenia. Another study
by Williams et al. (2007) compared first generation Caribbean Blacks with third
generation Caribbean Blacks in the United States. Researcher found that third generation
Blacks had markedly elevated rates of psychiatric disorders. The study revealed that
increased exposure to minority status in the United States was associated with higher
risks for psychiatric disorders among Black Caribbean immigrants, which possibly
reflects increased societal stress and downward social mobility associated with being
Black in America (Williams et al., 2007).

Subsequently, African immigrants experience mental health problems as they
navigate the process of living successfully in the United States. For instance, a study of
African-born immigrants settled in Washington D.C., New York City, Minneapolis-St.
Paul, and Atlanta revealed that mental health concerns are poorly characterized among
immigrants. Whereas hypertensive and diabetic clients were receiving medication, only
5% of clients with mental health problems were taking medication (Venters et al., 2011).

Social economic status, sex, and prior counseling experience variables have an
impact on attitudes toward seeking help. Duncan (1996) investigated factors that may
affect Black students’ counselor preference and attitudes toward counseling. The
researcher was interested in finding out, among other predictors, how African self-
consciousness (ASC), sex, social economic status (SES), prior counseling experience,
and cultural mistrust predict attitudes toward counseling. The researcher hypothesized
that these variables will predict attitudes toward counseling for Black college students.

Participants in Duncan’s (1996) study included 345 Black college students,
consisting of 131 males 38% and 214 females (62%). The sample had 3.6 % self-
identifying as lower class, 20.1% lower middle class, 47.8% middle class, 12.3% upper
middle class, and 16.2% upper class. The instruments used in this study consisted of a demographic questionnaire, the Cultural Trust Mistrust Inventory (CMI) (Terrel & Terrel, 1981), the Attitudes Toward Seeking Psychological Professional Help Scale (ATSPPHS) (Fischer & Turner, 1970), and the Counselor Preference Questionnaire (CPQ) (Thompson & Cimbolic, 1978). Results indicated cultural mistrust, SES, and sex were significant predictors of attitudes toward seeking psychological help among Black college students.

**Coping and Spiritual Well-Being**

Most African communities are collectivistic in nature. Wanjohi (1997) portrayed collectivist societies as finding meaning of life not only in philosophy but also in religion, living a balanced life (e.g., self-reliance counterbalanced with dependence and consideration of others), living with optimism (e.g., as revealed in their proverbs, belief in God, value of social life), and communal philosophy. In Kenyan communities, this idea is supported by the fact that most Kenyan immigrants resort to forming community or regional organizations or fellowship centers such as the Kenyan Americans Community Organization (KACO), Diaspora Council (DC), Kenya Christian Fellowship in America (KCFA), and Kenya Association Emergency Fund (KAEF), the Harambee Foundation (HF) among others, for mutual support and catering to their spiritual, social, financial, and mental health well-being. For this reason, it is important to consider the role of spirituality in coping and help-seeking among Kenyan immigrants in the United States. The paragraphs below discuss coping through symbolism and metaphors.

**Coping in Symbolism and Metaphors**

Africans use symbolism, metaphors, folklore, and imagery to illustrate and inculcate important ideas that could have mental health significance. For instance, Opuku
(1997) examined resilience of the African people as symbolized and explained in the Aya fern (*pteridophyte*) plant, which grows at the most unusual places, and is very difficult to destroy. The plant symbolizes courage and resilience in the face of adversity. Similar *Adinkra* symbols such as cloth imprinted with symbols convey knowledge and intelligible truths and ideas about life and meaning, without necessarily speaking. The *Sankofa* bird (e.g., head facing back and feet pointing forward) serves to remind the relevance of the past to the present, and the need to reach back and support those left behind for future success. The *teeth-tongue* symbol teaches and promotes coexistence with other societies (e.g., soft tongue lives with sharp teeth). These symbols act as catalysts of knowledge, wisdom, philosophy, ethics and morals that provoke further reflection and call for deeper thinking that could anchor the mind against adversity (Opuku, 1997). Similarly, Kenyans have a rich repertoire of imaginative vernacular folktales, which have didactic function toward moral and emotional development (Mwangi, 1983).

**Spiritual Well-Being**

The concept of spiritual well-being is a relatively new subject of exploration among Africans, and especially Kenyan immigrants in US. Although there are fundamental historical, social-economic, cultural, and religious differences between African Americans and African immigrants, there remains a key religious element that may have implications for Kenyan immigrants in the United States. For instance, Mattis (1997) explored the relationship between gender, spirituality, spiritual well-being, and several indices of religiosity including religious participation and religious motivation among African Americans. The researcher used a sample of 68 (27 male and 41 female)
African Americans recruited from a large university located in an urban setting in the Midwest. The mean age was 21 and mean level of education of 14.1 years. This study revealed that there were gender differences in the functions of religion in the lives of African American men and women. Twenty-two percent (22%) of the female respondents identified self-development as the most important current function of religion for them unlike men who did not endorse this category. The study found that women were significantly more likely than male cognates to participate in religious services early in life (Mattis). Women were also found more likely than men to express a need for faith and certainty. Overall, the spiritual well-being of African American men was moderately associated with the presence of externalizing agents in their lives; and for women, with spiritual orientation and the influence of external agents (Mattis, 1997). In the current study, it was, therefore, important to examine how demographic variables interface with spiritual well-being, religious participation, and attitudes toward psychological help among Kenyan immigrants in the United States. However, the data collected on spiritual well-being reflected the perception of the participants.

Religion and spirituality are believed to be important issues for the counseling profession. Olupona and Gemignani (2007) identified spirituality and expressive worship as major themes in the study of African immigrants’ religious experience in the United States. For instance, Ellison and Smith (1991) studied the relationship between religious involvement and subjective well-being, and found that respondents with strong religious faith reported higher levels of life satisfaction. The study further revealed that among older adults and persons with low levels of formal education, religious involvement was
correlated positively with existential certainty or a sense of coherence and order in one’s life (Ellison & Smith, 1991).

Kamya (1997) argued that for Africans, the spiritual is comprised of both a personal and communal aspect. It reflects a community’s preparedness and acknowledgement of something outside itself. Paloutzian and Ellison (1991) defined the concept of *spiritual well-being* as satisfaction with one’s relationship with God, with one’s sense of meaning and purpose in life and this concept will be examined as operationalized by the Spiritual Well-Being Scale (SWBS) (Ellison, 1983).

**Contrast of Western and Afrocentric Thought**

There is a clear dichotomy between Western individualistic and African collectivist cultures. The contrasting cultural worldview is likely to keep Kenyan immigrants away from seeking Western-based professional counseling (Leong, & Lau, 2001; Leong, Wagner, & Tata, 1995; Tumala-Narra, 2001; Yeh Inman, Kim, Okubo, 2006). It is well documented that the Western approach and practice of psychotherapy reflects a culture bound, mono-cultural perspective (Highlen, 1994; Katz, 1985; Sue, 1990) that is likely to alienate minority populations. These biases and assumptions are likely to be problematic to clients of African descent, especially Kenyan immigrants. Minority ethnic groups tend to place a high value on religious beliefs, a factor contributing to a sense of hope and optimism, meaning, and purpose in life, and better mental health (American Psychological Association, 2009). There remains a question of how globalization of counseling practice impacts varying cultures especially for immigrants from Kenya.
McGuiness et al. (2001) explored the application of a Western, psychologically based model of counseling training courses in contexts where the social and cultural conditions differ from mainstream Western societies with a focus of students from Kenya. This study observed that Kenyans are used to solutions and advice-type of counseling, without much respect for the individual’s decision. Many approached counseling expecting to be told what to do; hence, counselors need to be aware of cultural differences and expectations (McGuiness et al., 2001).

Moreover, there are fundamental philosophical differences between Western and African conceptualization of mental health. According to Nevid et al. (2005), the Western method of theory and treatment is heavily rooted in existential and humanistic theories, which owe their intellectual heritage to existential philosophers such as Søren Kierkegaard, Edmund Husserl, Martin Heidegger, and so forth. Hansen (2014) asserts that humanism tends to emphasize “structures of consciousness and subjective experience” (p. 175). In this case, existential therapists and humanistic therapists emphasize helping clients “become more aware of their conscious experiences and make personal choices that give their lives meaning and a sense of fulfillment” (Nevid et al., 2005, p. 540).

According to Hansen (2014), humanism promotes a unified self as a model of mental health, “setting a client on the path of self-actualization by progressively uniting formerly incongruent aspects of the self into a unified whole” (p. 175). Euro-centric theories incorporate psychodynamic concepts in their counseling approach by exploring “the analysis of defenses that people use to distort their feelings and experiences” (Nevid et al., 2005, p. 540), which is vastly different than the traditional African forms of helping
discussed earlier. The ideological foundations of humanism also promote pragmatism, arguing that, “an idea is true, so long as to believe it is profitable to our lives” (James, 1995, p.30). Furthermore, Hansen, Speciale, and Lemberger (2014) asserted that Western theory of counseling is founded in humanistic ideals with elements of modernism and postmodernism, and rooted in Renaissance intellectualism. The implications of this are discussed further in the paragraphs below, with specific emphasis on implications for mental health treatment.

**Wisdom of the African Elders Preferred**

As aforementioned, in the event a person experiences a personal, interpersonal, or family problem, a well-respected relative, clan elder, or traditional healer is consulted. Dalfovo (1991) argued that the authoritative core of traditional society is the elder as the head of the family. Elders are highly esteemed and regarded as the repository of knowledge and vast experience, intelligence, logic, and verbal or oral wit. Oluwole (1997) asserted that elders use the wisdom found in African proverbs: “the analytic tools of thought, when thought is lost, it is proverbs that are used to search for it” and proverbs “are the palm oil with which words are eaten.” Elders are likely to be preferred as informal counselors for their liberal use of wisdom found in proverbs. For instance, the Yoruba of Nigeria remind that, “A wise man who knows proverbs, reconciles difficulties.” The visionary attribute of the elders is found in the sayings, “An elder sitting on a three-legged stool sees further than a young man highly perched on a tree,” “A giraffe sees further than all other animals,” and “There is no wall without supporting poles.” Elders are also held in prestigious status, as illustrated through the saying, “A child who can wash his hands clean may eat with the elders.” They are considered patient
in determining cases: “The elders drink afterwards,” referring to elderly people as in less of a hurry to make decisions compared to young people. The use of these proverbs may serve to preclude and or disqualify a professionally trained counselor in favor of a respected elder.

Nussbaum (2000) differentiated Western thought from African common wisdom by arguing that the Western paradigm of wisdom is elitist, as found in the writings done by great thinkers such as Aristotle, Aquinas, Descartes, Kant, Marx and so forth. Conversely, Africans have no “great thinkers” and wisdom found in proverbs has no authors. Proverbs come from the group and belong to the group. Therefore, the African proverb becomes relevant not because of who coined it but who is and the reason for quoting it (Nussbaum, 2000). In Western thought, expertise is presented as wisdom; whereas from the African standpoint, true wisdom will be widely known, not knowing more than the other, but of cleverly reminding others what they already know and thus persuading them to live wisely (Brown, 2000). It can therefore be argued that most Africans are counseled, acquire new wisdom and knowledge through daily and sometimes informal conversations (Kai, 2011; Orwenjo, 2009), and use it when in need of sorting out difficult situations. Consequently, this may limit the need to seek professional counseling services.

Penfield and Duru (1988) emphasized that the use of proverbs as metaphors in social interaction allows the extension of language and the creation of new reality. The linguistic nature of the proverb has a powerful psychological effect on the audience, represents a mental challenge to the addressee, and puts someone in a mode of relaxation to think. Proverbs have been used in other disciplines as effective tools to enlighten and
teach certain topics that may be considered taboo (e.g., social justice, Asimeng-Boahene, 2012; in political discourse (Orwenjo, 2009), conversations in marriage (Rowe & Rowe, 2009), and in neurology and speech pathology (Brown, 2000).

**African Ubuntu-ism and Mental Health**

_Ubuntu_, with its origins of Abantu (people), is a Bantu ontological noun describing what it means to be a member of humankind. Mnyandu (1997) explained the collectiveness and interdependence of the Ubuntu “personhood” or “humanness” worldview. This is captured in the African tenet, “motho ke motho ka batho” (in sotho African language), which means a human being is human through the otherness of other human beings, and is described as the soul of African society (Mnyandu, 1997). The aim of Ubuntu therapy is to increase “humanness” since “the person possessing the greater degree of it is praised as being caring, humble, thoughtful, considerate, understanding, wise, godly, generous, hospitable, mature, virtuous, and blessed” (Mnyandu, 1997, p. 103). The process of Ubuntu therapy, therefore, focuses on telling the “story” whereby the therapist listens and analyzes the client’s story. The aim of the analysis is to determine the dimension at which conflict is occurring at a psycho-theological, intra-psychic, or interpersonal level. Conversely, the absence of Ubuntu creates tension, conflicts, frustrations, and disintegration of basic human relationship and community. The communal value of Ubuntu assists in the building of good interpersonal relationships and leads to human value, dignity and trust, thereby enhancing social harmony and cohesion (Mnyandu, 1997). Undergoing the process of Ubuntu therapy may preclude the need for traditional forms of professional counseling among Kenyan immigrants.
Summary

It has been noted that the attrition rate of ethnic minority clients from therapy is more than 50% after only one contact with a therapist. This is in marked contrast to the less than 30% termination rate among White clients (Sue & Sue, 2004). Minorities tend to drop out of counseling earlier, and are less likely to have positive outcomes from counseling in which they do engage (Sue & Sue, 2004). Nwadiora (1996) observed that most Africans turn to elders, pastors, and community leaders for direction and the idea of seeking professional Western therapy may be alien to them, and may affect their perceptions of professional counseling in the United States.

This chapter has discussed topics relevant specifically to the study of help-seeking attitudes among Kenyan immigrants in the United States, including: (a) Kenyan immigrants in the United States; (b) the historical, socioeconomic, and cultural contexts from which Kenyans immigrate; (c) mental health concerns of Kenyan immigrants living in the United States; (d) perceived barriers to care; (e) attitudes toward seeking professional counseling; (f) coping and spiritual well-being; and (g) the contrast between Afrocentric and Western thought. It is clear from this review of literature that Kenyan immigrants experience unique stressors once arriving to the United States, and may also be affected by cultural and ecological barriers to mental health care.
CHAPTER III

RESEARCH METHODOLOGY

This chapter provides a detailed rationale of the methodology that was utilized to conduct this study. As indicated in Chapter I, the primary purpose of this research was to examine attitudes toward seeking professional psychological help among Kenyan immigrants living in the United States. The study also examined the relationships among those attitudes, and various demographic characteristics and spiritual well-being. The following sections provide information on the: (a) research questions, (b) research design, (c) participants and sampling methods, (d) instrumentation, (e) data collection procedures, and (f) methods of data analysis that was utilized for this study.

Research Questions and Hypotheses

The purpose of this study was to: (a) examine attitudes toward seeking professional psychological help among Kenyan immigrants living in the United States, and (b) examine the relationships among attitudes toward seeking professional psychological help among Kenyan immigrants, and various demographic characteristics and spiritual well-being. Based on the purpose of this study, the questions and associated hypotheses that guided this quantitative research are as follows:

1. What is the relationship between demographic variables (i.e., gender, education, and marital status) and attitudes toward seeking professional counseling for Kenyan immigrants in the United States?

Hypothesis 1: There is a statistically significant relationship between gender, education, and marital status and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States.
2. What is the relationship between spiritual well-being, level of acculturation, and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States?

**Hypothesis 2**: There is a statistically significant relationship between spiritual well-being, level of acculturation, and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States.

**Research Design**

This quantitative study utilized a descriptive survey approach to describe attitudes toward seeking professional psychological help among Kenyan immigrants living in the United States. Despite its inability to probe as in-depth as the qualitative method, survey research is very useful in identifying respondents’ attitudes and perceptions (Walonick, 1998). According to Cresswell (2003), descriptive survey research is used to test hypotheses and answer questions regarding the current status of the population involved in a study. It is purposely employed to generalize from a sample to a larger population. In this case, this researcher gathered information concerning the demographics, attitudes, behaviors, and beliefs of a subset of the Kenyan population living in the United States, which may then be generalized to the larger group. Survey research allows researchers to collect data from a cross-sectional population to ensure the participants of the survey are representative of the larger population (Leary, 2004).

**Participants and Sampling Methods**

Participants for this study consisted of Kenyan immigrants, who are 18 years or older and currently living in the United States. As aforementioned, immigrants generally settle in large cities for various reasons, including seeking advanced education and
lucrative economic opportunities. Kenyan immigrants are largely found in major metropolitan areas in states like Massachusetts, New York, Maryland, Washington, D.C., Minnesota, Georgia, Texas, Kansas, North Carolina, Ohio, Indiana, Washington, and Illinois. This researcher employed a purposeful sampling method of identifying major conclaves where Kenyans are located and gather for various functions. By so doing, the selected sample provides the best information to address the purpose of the research, and be representative of the population (McMillan & Schumacher, 1997).

Since the Kenyan population is distributed across the United States, it was necessary to employ a snowball sampling method. This involved participants referring others who fit the profile and met the criteria for participation in the study.

**Inclusionary Criteria**

The criteria for inclusion to participate in this research study was any adult Kenyan, 18 years or older, who were born in Kenya, immigrated, and currently living within the United States. My objective was to generalize my findings from the sample to the larger population of Kenyan immigrants. Since spiritual well-being is an important construct in this study, religious diversity of participants was an important sampling consideration. Therefore, subjects were recruited from churches of different faiths and community organizations that were not affiliated to churches. Online participation was included to allow for geographical distribution and diversity of Kenyans currently living in the United States and to ensure that the sample is representative of the larger population of interest.
Exclusionary Criteria

Non-Kenyans and Kenyans living outside the United States were excluded from this study.

Risks and Protection of Participants

The primary risk associated with this study was the loss of time spent completing the survey. Other anticipated minimal risks may have included fear of revealing personal attitudes toward seeking psychological help, which may be sensitive to some participants given the stigma associated with mental health issues.

Benefits of the Research

There was no direct benefit compensation for those who participated in this research. Indirect benefits of participation in this study included satisfaction obtained from contributing to knowledge in this subject area, which may then be used to better inform mental health professionals, educators, policymakers, and thought leaders who work with Kenyan immigrants living in the United States.

Confidentiality of the Data

The researcher minimized risk by maintaining confidentiality and not associating identifying information with responses. The researcher took steps to ensure the confidentiality of the data obtained. Names were not collected as part of this research. The researcher was the only person with access to completed surveys and stored the surveys in a locked cabinet following the data collection process.

The second step was securing the data once it was transferred from the paper to computer file (using SPSS) and saved on a jump drive. The jump drive was securely kept in a locked cabinet, and only the researcher and statistical consultant had access to the
electronic files. Additionally, a copy of the original data was made on a CD and will be kept in a locked cabinet in the principal investigator’s office and retained for a minimum of three years as per federal regulations.

**Instrumentation**

Instrumentation for this dissertation study consisted of: (a) a demographic questionnaire, (b) the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH; Fischer & Turner, 1970), and (c) the Spiritual Well-Being Scale (SWBS; Paloutzian & Ellison, 1991).

**Demographic Questionnaire**

A 23-item questionnaire was used to collect data concerning participants’ demographic and acculturation characteristics as in Appendix A. Items 1 through 8 assessed participants’ general background information, including gender, age, marital status, annual income, education, geographic region of birth, age at time of immigration, and years lived in the United States. Items 9 through 18 included questions thought necessary to measure psychological acculturation (Tropp, Erkut, Coll, Alarcon, & Garcia, 1999). Finally, items 19 through 23 explored religious affiliation, and individuals’ participants have consulted for psychological or emotional problems and preference of a helper in case of experiencing psychological distress.

**Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS)**

The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH; Fischer & Turner, 1970) in Appendix B is widely used for conceptualization of help-seeking attitudes in United States and other countries (Masuda et al., 2005). The instrument consists of 29 items designed to assess general attitudes toward seeking
professional help for psychological problems and issues. Fischer and Turner (1970) found four factors for the ATSPPH scale. These factors are: (1) Recognition of Personal Need for Psychological Help (8 items); (2) Stigma Tolerance Associated with Psychological Help (5 items); (3) Interpersonal Openness Regarding One’s Problems (7 items); and (4) Confidence in Mental-Health Professional (9 items). Items are rated using a 4-point Likert-type scale ranging from 0 (disagree) to 3 (agree). Eleven items are scored positively so that agreement indicates positive attitudes, and 18 are scored negatively so that disagreement with the item shows negative attitudes toward psychological help. Total scores range from 0 to 87, with a higher score indicating positive attitudes toward psychological help seeking. Internal reliability estimates as measured by coefficient alpha for the entire scale range from .83 to .73 and for the four factors range from .74 to .62 and from .76 to .53 (Fischer & Turner, 1970; Good & Wood, 1995). Test–retest reliability of .89 for a 2-week interval to .84 for a 2-month interval. Additionally, Fischer and Turner (1970) provided support for the construct validity of the scale.

**Spiritual Well-Being Scale (SWBS)**

The Spiritual Well-Being Scale (SWBS; Paloutzian & Ellison, 1991) in Appendix C is the most extensively researched measure of subjective spiritual well-being (Bruce, 1996). According to Paloutzian and Ellison (1991), the scale is frequently used in research for the assessment of both individual and congregational spiritual well-being. Traditionally, spiritual well-being as an aspect of one’s spirituality is described as a barometer of how well a person is doing despite challenges (Paloutzian, Bufford, & Wildman, 2012). The SWBS contains two components: (a) the Religious Well-Being (RWB) subscale and (b) the Existential Well-Being (EWB) subscale. The RWB is a
vertical dimension in which well-being is measured in relation and reference to God. Two examples of items on this subscale are, “I have a personally meaningful relationship with God” and “I believe that God is concerned about my problems.” The EWB is a horizontal dimension that measures well-being in terms of an individual’s sense of life purpose, or the extent to which he or she “know[s] what to do and why, who we are, and where we belong in relation to ultimate concerns” (Paloutzian & Ellison, 1991, p. 331). Two examples of items on this subscale are, “I feel unsettled about my future” and “Life doesn’t have much meaning.”

The SWBS, a 20-item Likert-type scale, is self-administered and measures the degree to which respondents agree with a given statement. Higher scores indicate greater spiritual well-being. The 10 even-numbered items produce the EWB, while the 10 odd-numbered items produce the RWB. All 20 items produce a Total Spiritual Well-Being (SWB) score (Paloutzian & Ellison, 1991).

Reliability coefficients for both subscales and the total scale are high. Test-retest reliability coefficients range from .88 to .99, with the test-retest intervals ranging from 1 to 10 weeks. Internal consistency from seven studies revealed coefficient alphas with the following ranges: .82 to .94 for the RWB, .78 to .86 for the EWB, and .89 to .94 for the total SWB. The reverse scoring of nine items helps to guard against response bias. Test-retest reliability correlation coefficients are SWB .93, RWB .86, and EWB .86 (Paloutzian & Ellison, 1991). The SWBS has good face validity regarding the content of the items. Items cluster as expected into the subscales and research has supported the SWBS as a good indicator of well-being, while being sensitive to a lack of well-being. For the Religious Well-Being score (RWB), a score in the range of 10 to 20 reflects a
sense of unsatisfactory relationship with God, 21 to 49 moderate sense of religious well-being, and 50 to 60 a positive view of one’s relationship with God. For the Existential Well-Being (EWB), a score in the range of 10 to 20 suggests a low satisfaction with one’s life and possible lack of clarity about ones’ purpose in life, a range of 21 to 49 suggests moderate level and 50 to 60 high level of life satisfaction with one’s life and clear sense of purpose (Paloutzian & Ellison, 1991).

**Data Collection Procedures**

Following the approval of the proposed study by the Western Michigan University Human Subjects Institutional Review Board (HSIRB), this researcher established contact with church and community association leaders through public email links and telephone contacts in order to access a large target population and solicit participation in the study (Appendix D). In the United States, Kenyans are largely found in major metropolitan areas, and many belong to Kenyan community churches and other common interest organizations. This researcher planned to recruit a minimum of 150 participants who met the criteria to participate in this study and ensured that the sample was representative of the larger and diverse population of interest. Researchers suggest that as the number of participants used in a study increases, so does the probability that the sample is representative of the population (Heppner, Kivlighan, & Wampold, 1999). Church and community leaders who agreed to assist the researcher with the study were mailed packets containing the ATSPPH (Fischer & Turner 1970), SWBS (Paloutzian & Ellison, 1991), demographic questionnaire, an informed consent document Appendix E, and a self-addressed, postage paid return envelope. Additionally, this researcher attended designated church activities to inform attendees about the study. Permission from the
church leader/pastor was sought to personally speak to the church attendees to explain the study and its purpose and to solicit participation. Potential participants who expressed interest were asked to meet with the researcher in a designated area after the church service. Participants unable to complete the surveys at church but were willing to participate were given a survey packet to complete and return the completed survey in a postage-paid, return addressed envelope. The researcher distributed the anonymous consent form, the survey and an envelope in which to put the completed survey and asked participants to complete the survey on site during the respective meetings. The researcher left the room to ensure anonymity and minimize social desirability. The researcher returned to the room to collect completed surveys. A follow-up email was sent to church and community leaders who did not respond to the initial invitation within two weeks (Appendix F). A final follow-up email was sent within the subsequent two weeks.

This researcher also collected data online through the use of electronic module posted on Mwakilishi.com, a Kenya diaspora newspaper. Another link was sent to the Kenya Scholars and Studies Association (KESSA) that is accessed by Kenyan scholars in higher education in the United States. Permission to post an invitation to potential participants was sought from the Webmasters or List-Serve moderators. Willing participants clicked on the invitation that connected them to the informed consent form.

**Data Analysis**

As mentioned in the Data Collection Procedures section above, data for this study was collected using online and paper and pencil version of the survey instruments. Collected data was entered into the Statistical Package for Social Sciences (SPSS) program version 19 for analyses. Preliminary data analysis consisted of obtaining
descriptive statistics (e.g., frequencies, mean, median, standard deviation, etc.) for all demographic questionnaire, ATSPPHS (Fischer & Turner, 1970), and SWBS (Paloutzian & Ellison, 1991) items. Additionally, a psychological acculturation variable was created by obtaining the mean of items 9 through 18, as described by Tropp et al. (1999). Once descriptive statistics were obtained, inferential statistics were used to answer the study’s research questions.

**Research Question 1**

1. What is the relationship between demographic variables (i.e., gender, education, and marital status) and attitudes toward seeking professional counseling for Kenyan immigrants in the United States?

   **Hypothesis 1:** There is a statistically significant relationship between gender, education, and marital status and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States.

   Research question 1 was answered using a MANOVA analysis for each dependent variable. The independent variables were represented by the demographic characteristics: (a) gender, (b) education, and (c) marital status. The dependent variables were: (a) Recognition of Personal Need for Psychological Help; (b) Stigma Tolerance Associated with Psychological Help; (c) Interpersonal Openness Regarding One’s Problems; (d) Confidence in Mental-Health Professional; and (e) total ATSPPH scores. The alpha for this study was based on the accepted significance level of 0.05.

**Research Question 2**

2. What is the relationship between spiritual well-being, level of acculturation, and attitudes toward seeking professional psychological help for Kenyan immigrants in
the United States?

**Hypothesis 2:** There is a statistically significant relationship between spiritual well-being, level of acculturation, and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States.

Research question 2 was answered using another series of five general linear multiple regression analyses. The independent variables include: Psychological Acculturation, EWB, RWB, and SWB. The dependent variables were: (a) Recognition of Personal Need for Psychological Help; (b) Stigma Tolerance Associated with Psychological Help; (c) Interpersonal Openness Regarding One’s Problems; (d) Confidence in Mental-Health Professional; and (e) total ATSPPH scores. Again, a correlation matrix for all independent and dependent variables was obtained, and the alpha level was set at 0.05.

**Summary**

Chapter III described the methodology that was used to conduct this study. A descriptive survey approach was used to collect data from Kenyan immigrant adults living in the United States. Instrumentation included the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970), the Spiritual Well-Being Scale (Paloutzian & Ellison, 1991), and a demographic questionnaire that includes items to assess psychological acculturation (Tropp et al., 1999). Obtained data was entered into SPSS and analyzed using MANOVA and general linear multiple regression respectively to answer both of the study’s research questions.
CHAPTER IV
RESULTS

The purpose of this study was first to examine the relationship between demographic variables (i.e., marital status, age, income, gender, length of stay, level of education, level of acculturation, and attitudes toward seeking professional psychological counseling for Kenyan immigrants in the United States. Second, this study sought to examine the relationship between spiritual well-being, level of acculturation, and attitudes toward seeking professional psychological help. The first two sections of this chapter provide descriptions of the sample population and preliminary analyses. The next section shows reliabilities of the measures used in this study, and the final section concludes with the results of the statistical tests used to analyze the data in this study.

Description of Participants

A total of 279 Kenyan immigrants who live in the United States willingly completed the questionnaires. A total of 141 individuals completed paper and pencil questionnaires, while 138 individuals elected online participation. The sample was evenly distributed gender-wise with 49.0% \((n = 139)\) female and 50.2% \((n = 140)\) male. Regarding marital status over half, 61.6% \((n = 172)\) of the participants self-reported as being married, 25.8% \((n = 72)\) were single, 10.4% \((n = 29)\) were divorced and 2.2% \((n = 6)\) were widowed.

As it relates to financial status, 21.5% \((n = 60)\) reported earnings of less than $15,000 to $25,000 per year; 39.4% \((n = 110)\) reported earnings between $25,001 to $50,000 per year; 24.4% \((n = 68)\) reported earnings between $50,001 to $75,000 per year; and finally 14.7% \((n = 41)\) reported earnings between $75,001 to $85,000 and over.
Participants’ education level varied from a minimum of less than high school to a maximum of doctoral level: there were .7% (n = 2) with less than high school; 9.0% (n = 24) with high school education; 30.1% (n = 84) with some college; 30.5% (n = 85) received bachelor’s degree; 24% (n = 67) were master’s degree holders; and 5.7% (n = 16) earned their doctorate.

With reference to geographic region of birth, 60.6 % (n =168) reported having lived in rural areas of Kenya, and 38.7 % (n = 108) in the urban area of Kenya prior to migrating to the United States. The sample (N = 279) reported an overall age range of 18 to 65 and over with 48% with a mean of age category of between 35 to 44 years. Regarding the age at the time of migration to the United States, 41% (n = 114) were between the age of 18 to 24 years, while 50% (n = 139) reported were between the age of 25 to 44 years, and 9% (n = 25) were between the age of 45 to 65 years. Participants’ length of time in the United States varied from 1 year to over 20 years. Seventeen percent (n = 47) reported having stayed 1 to 5 years. Sixty-two percent (n = 172) lived between 6 and 10 years, and 7% (n = 57) from 11 to 20 years.

The distribution of the sample based on religious affiliation indicated that 11.2% (n = 28) were Anglican; 6.0% (n = 15) were African Inland; 1.2% (n = 3) Methodist; 13.5% (n = 34) were Pentecostal; 15.9% (n = 40) were Presbyterian; 14.3% (n = 36) were Roman Catholic; 22.7% (n = 57) were Seventh Day Adventist; .8% (n = 2) were Traditionalist; 12.7% (n = 32) were non-denominational; and 1.6% (n = 4) considered themselves of a different denomination.

Data was also collected to examine how often the participants attended worship service. The majority of the participants (46.4%, n = 124) reported they attend church
service every week; 31.5% \((n = 84)\) reported attending at least once or twice every month; 22.1% \((n = 59)\) attended occasionally or never; and 4.3% \((n = 12)\) did not respond.

In regard to past contact with a spiritual leader for psychological or emotional problem, 27.4% \((n = 73)\) of the sample reported having previous contact experience with a spiritual leader, 72.6% \((n = 193)\) reported no previous contact experience, and 5% \((n = 13)\) did not respond to the question.

As it relates to past consultation with mental health professionals for psychological or emotional problems, 13.6 \((n = 38)\) of the sample reported having previous contact experience with a mental health professional and 81.4% \((n = 227)\) reported no previous contact or experience. However, 5% \((n = 14)\) did not respond to this question.

Data was collected to examine with who participants would consult if they experienced a psychological or emotional problem. The majority of the participants 19.4% \((n = 54)\) reported they would consult with the clergy/pastor; 17.9% \((n = 50)\) with a trusted friend; 16.1% \((n = 45)\) with their family; 11.5% \((n = 32)\) with a professional counselor or therapist; 4.7% \((n = 13)\) with a psychologist; 3.6% \((n = 10)\) with a physician; .7% \((n = 2)\) with a psychiatrist; and 5.7% \((n = 16)\) would not seek help from the options provided. Additionally, 4.7% \((n = 13)\) did not respond to the question. It is important to note that although participants were asked to select only one option, 14.0% \((n = 39)\) selected multiple options thus indicating that they were open to seek help from more than one source. Table 1 provides a summary of all participant demographic data.
Table 1

*Summary Description of Participants*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>140</td>
<td>50.2</td>
</tr>
<tr>
<td>Female</td>
<td>139</td>
<td>49.0</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>72</td>
<td>25.8</td>
</tr>
<tr>
<td>Married</td>
<td>172</td>
<td>61.6</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>29</td>
<td>10.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>6</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$15,000 to $25,000</td>
<td>60</td>
<td>21.5</td>
</tr>
<tr>
<td>$25,001 to $50,000</td>
<td>110</td>
<td>39.4</td>
</tr>
<tr>
<td>$50,001 to $75,000</td>
<td>68</td>
<td>24.4</td>
</tr>
<tr>
<td>$75,001 to $85,000 and over</td>
<td>41</td>
<td>14.7</td>
</tr>
<tr>
<td><strong>Level of Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>2</td>
<td>7.0</td>
</tr>
<tr>
<td>High school education</td>
<td>24</td>
<td>9.0</td>
</tr>
<tr>
<td>Some college</td>
<td>84</td>
<td>30.1</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>85</td>
<td>30.5</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>67</td>
<td>24.0</td>
</tr>
<tr>
<td>Doctorate</td>
<td>16</td>
<td>5.7</td>
</tr>
<tr>
<td><strong>Geographic Region at Birth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>168</td>
<td>60.6</td>
</tr>
<tr>
<td>Urban</td>
<td>108</td>
<td>38.7</td>
</tr>
</tbody>
</table>
Table 1—Continued

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age at Time of Emigrating</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>114</td>
<td>41.0</td>
</tr>
<tr>
<td>25-44</td>
<td>139</td>
<td>50.0</td>
</tr>
<tr>
<td>45-65</td>
<td>25</td>
<td>9.0</td>
</tr>
<tr>
<td><strong>Length of Time in the United States</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 5 years</td>
<td>47</td>
<td>17.0</td>
</tr>
<tr>
<td>6-10 years</td>
<td>172</td>
<td>62.0</td>
</tr>
<tr>
<td>11-20 years</td>
<td>57</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>Religious Affiliation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anglican</td>
<td>28</td>
<td>11.2</td>
</tr>
<tr>
<td>African Inland</td>
<td>15</td>
<td>6.0</td>
</tr>
<tr>
<td>Methodist</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Pentecostal</td>
<td>34</td>
<td>13.5</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>40</td>
<td>15.9</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>36</td>
<td>14.3</td>
</tr>
<tr>
<td>Seventh Day Adventist</td>
<td>57</td>
<td>22.7</td>
</tr>
<tr>
<td>Traditionalist</td>
<td>2</td>
<td>.8</td>
</tr>
<tr>
<td>Non-denominational</td>
<td>32</td>
<td>12.7</td>
</tr>
<tr>
<td>Other denomination</td>
<td>4</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Frequency of Church Attendance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every week</td>
<td>124</td>
<td>46.4</td>
</tr>
<tr>
<td>At least once or twice per month</td>
<td>84</td>
<td>31.5</td>
</tr>
<tr>
<td>Occasionally</td>
<td>59</td>
<td>22.1</td>
</tr>
<tr>
<td>Missing</td>
<td>12</td>
<td>4.3</td>
</tr>
</tbody>
</table>
Table 1—Continued

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consulted a Spiritual Leader</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>73</td>
<td>27.4</td>
</tr>
<tr>
<td>No</td>
<td>193</td>
<td>72.6</td>
</tr>
<tr>
<td>Missing</td>
<td>13</td>
<td>5.0</td>
</tr>
<tr>
<td>Consulted a Mental Health Professional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>38</td>
<td>13.6</td>
</tr>
<tr>
<td>No</td>
<td>227</td>
<td>81.4</td>
</tr>
<tr>
<td>Missing</td>
<td>14</td>
<td>5.9</td>
</tr>
<tr>
<td>Who would you consult (valid cases were 227 and 52 were treated as missing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clergy</td>
<td>54</td>
<td>19.4</td>
</tr>
<tr>
<td>Trusted friend</td>
<td>50</td>
<td>17.9</td>
</tr>
<tr>
<td>Family</td>
<td>45</td>
<td>16.1</td>
</tr>
<tr>
<td>Counselor/therapist</td>
<td>32</td>
<td>11.5</td>
</tr>
<tr>
<td>No one</td>
<td>16</td>
<td>5.7</td>
</tr>
<tr>
<td>Psychologist</td>
<td>13</td>
<td>4.7</td>
</tr>
<tr>
<td>Physician</td>
<td>10</td>
<td>3.6</td>
</tr>
<tr>
<td>Respected elder</td>
<td>5</td>
<td>1.8</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>2</td>
<td>.7</td>
</tr>
<tr>
<td>Multiple choices</td>
<td>39</td>
<td>14.0</td>
</tr>
<tr>
<td>Missing</td>
<td>13</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Descriptive Statistics

Descriptive statistics for the total ATSPPHS and its subscales, total SWBS and its subscales, and total acculturation are presented in Table 2. Descriptive statistics for items on the ATSPPH, SWB, and Acculturation scales are presented in Tables 3 through 5.
### Table 2

**Descriptive Statistics for the Total ATSPPHS, ATSPPH Subscales, Total SWB, SWB Subscales, and Total Psychological Acculturation**

<table>
<thead>
<tr>
<th>Scale</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Attitude Toward Seeking Professional Help Scale (^a)</td>
<td>223</td>
<td>54.12</td>
<td>13.18</td>
</tr>
<tr>
<td>Recognition of Personal Need for Professional Psychological Help (^b)</td>
<td>240</td>
<td>14.21</td>
<td>4.46</td>
</tr>
<tr>
<td>Tolerance of the Stigma Associated with Psychiatric Help (^c)</td>
<td>242</td>
<td>9.14</td>
<td>3.19</td>
</tr>
<tr>
<td>Interpersonal Openness Regarding One's Problems (^d)</td>
<td>235</td>
<td>12.62</td>
<td>4.29</td>
</tr>
<tr>
<td>Confidence in the Mental Health Professional (^e)</td>
<td>246</td>
<td>10.20</td>
<td>2.92</td>
</tr>
<tr>
<td>Total Spiritual Well-Being (^f)</td>
<td>228</td>
<td>101.30</td>
<td>16.17</td>
</tr>
<tr>
<td>Religious Well-Being (^g)</td>
<td>238</td>
<td>51.90</td>
<td>9.70</td>
</tr>
<tr>
<td>Existential Well-Being (^h)</td>
<td>234</td>
<td>49.10</td>
<td>8.92</td>
</tr>
<tr>
<td>Total Psychological Acculturation (^i)</td>
<td>260</td>
<td>30.72</td>
<td>15.64</td>
</tr>
</tbody>
</table>

\(^a\) Highest possible ATSPPHS score is 87.
\(^b\) Highest possible Recognition of Personal Need score is 24.
\(^c\) Highest possible Tolerance of Stigma score is 15.
\(^d\) Highest possible Interpersonal Openness score is 21.
\(^e\) Highest possible Confidence in the Mental Health Profession score is 27.
\(^f\) Highest possible Spiritual Well-Being score is 120.
\(^g\) Highest possible Religious Well-Being score is 60.
\(^h\) Highest possible Existential Well-Being score is 60.
\(^i\) Highest possible Psychological Acculturation score is 90.

### Table 3

**Descriptive Statistics for ATSPPH Items**

<table>
<thead>
<tr>
<th>Items</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of Personal Need for Professional Psychological Help</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist</td>
<td>253</td>
<td>1.97</td>
<td>1.11</td>
</tr>
<tr>
<td>5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.</td>
<td>250</td>
<td>1.73</td>
<td>1.19</td>
</tr>
<tr>
<td>6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.</td>
<td>251</td>
<td>1.96</td>
<td>1.09</td>
</tr>
<tr>
<td>9. Emotional difficulties, like many things, tend to work out by themselves.</td>
<td>250</td>
<td>2.01</td>
<td>1.04</td>
</tr>
</tbody>
</table>
Table 3—Continued

<table>
<thead>
<tr>
<th>Items</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recognition of Personal Need for Professional Psychological Help</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. I would want to get psychiatric attention if I was worried or upset for a long period of time</td>
<td>248</td>
<td>1.81</td>
<td>1.11</td>
</tr>
<tr>
<td>24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help</td>
<td>248</td>
<td>1.64</td>
<td>1.11</td>
</tr>
<tr>
<td>25. At some future time I might want to have psychological counseling.</td>
<td>246</td>
<td>1.31</td>
<td>1.09</td>
</tr>
<tr>
<td>26. A person should work out his own problems; getting psychological counseling would be a last resort.</td>
<td>246</td>
<td>1.80</td>
<td>1.11</td>
</tr>
<tr>
<td><strong>Tolerance of the Stigma Associated with Psychiatric Help</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I would feel uneasy going to a psychiatrist because of what some people would think.</td>
<td>253</td>
<td>1.98</td>
<td>1.09</td>
</tr>
<tr>
<td>14. Having been a psychiatric patient is a blot on a person’s life.</td>
<td>246</td>
<td>2.00</td>
<td>1.04</td>
</tr>
<tr>
<td>20. Having been mentally ill carries with it a burden of shame.</td>
<td>248</td>
<td>1.85</td>
<td>1.17</td>
</tr>
<tr>
<td>27. Had I received treatment in a mental hospital, I would not feel that it ought to be “covered up.”</td>
<td>246</td>
<td>1.29</td>
<td>1.15</td>
</tr>
<tr>
<td>28. If I thought I needed psychiatric help, I would get it no matter who knew about.</td>
<td>247</td>
<td>2.07</td>
<td>1.09</td>
</tr>
<tr>
<td><strong>Interpersonal Openness Regarding One's Problems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family</td>
<td>249</td>
<td>2.37</td>
<td>.89</td>
</tr>
<tr>
<td>10. There are certain problems which should not be discussed outside of one’s immediate family.</td>
<td>249</td>
<td>1.34</td>
<td>1.18</td>
</tr>
<tr>
<td>13. Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns.</td>
<td>245</td>
<td>1.74</td>
<td>1.12</td>
</tr>
<tr>
<td>17. I resent a person-professionally trained or not-who wants to know about my personal difficulties.</td>
<td>245</td>
<td>2.03</td>
<td>1.02</td>
</tr>
<tr>
<td>21. There are experiences in my life I would not discuss with anyone.</td>
<td>247</td>
<td>1.25</td>
<td>1.15</td>
</tr>
<tr>
<td>22. It is probably best not to know everything about oneself.</td>
<td>246</td>
<td>1.82</td>
<td>1.17</td>
</tr>
<tr>
<td>29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.</td>
<td>249</td>
<td>2.09</td>
<td>1.09</td>
</tr>
</tbody>
</table>
Table 3—Continued

<table>
<thead>
<tr>
<th>Items</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Confidence in the Mental Health Professional</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Although there are clinics for people with mental troubles, I would not have much faith in them.</td>
<td>253</td>
<td>1.91</td>
<td>1.07</td>
</tr>
<tr>
<td>2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.</td>
<td>253</td>
<td>2.18</td>
<td>.95</td>
</tr>
<tr>
<td>8. I would rather live with certain mental conflict than go through the ordeal of getting psychiatric treatment.</td>
<td>249</td>
<td>2.41</td>
<td>.90</td>
</tr>
<tr>
<td>11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.</td>
<td>248</td>
<td>1.83</td>
<td>1.07</td>
</tr>
<tr>
<td>12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.</td>
<td>248</td>
<td>1.88</td>
<td>1.11</td>
</tr>
<tr>
<td>15. I would rather live with certain mental conflict than go through the ordeal of getting psychiatric treatment.</td>
<td>249</td>
<td>2.41</td>
<td>.90</td>
</tr>
<tr>
<td>16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help</td>
<td>248</td>
<td>1.99</td>
<td>1.03</td>
</tr>
<tr>
<td>19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.</td>
<td>248</td>
<td>2.39</td>
<td>.98</td>
</tr>
<tr>
<td>23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.</td>
<td>247</td>
<td>2.06</td>
<td>.95</td>
</tr>
</tbody>
</table>

Table 4

Descriptive Statistics for Spiritual Well-Being Items

<table>
<thead>
<tr>
<th>Items a</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Religious Well-Being</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. I don't find much satisfaction in private prayer with God. b</td>
<td>244</td>
<td>4.95</td>
<td>1.64</td>
</tr>
<tr>
<td>3. I believe that God loves me and cares about me.</td>
<td>245</td>
<td>5.45</td>
<td>1.34</td>
</tr>
<tr>
<td>5. I believe that God is impersonal and not interested in my daily situations.</td>
<td>245</td>
<td>5.07</td>
<td>1.61</td>
</tr>
<tr>
<td>7. I have a personally meaningful relationship with God.</td>
<td>245</td>
<td>5.19</td>
<td>1.28</td>
</tr>
<tr>
<td>9. I don't get much personal strength and support from my God</td>
<td>245</td>
<td>5.11</td>
<td>1.49</td>
</tr>
<tr>
<td>11. I believe that God is concerned about my problems.</td>
<td>244</td>
<td>5.23</td>
<td>1.45</td>
</tr>
<tr>
<td>13. I don't have a personally satisfying relationship with God.</td>
<td>244</td>
<td>4.84</td>
<td>1.66</td>
</tr>
<tr>
<td>15. My relationship with God helps me not to feel lonely.</td>
<td>244</td>
<td>5.11</td>
<td>1.41</td>
</tr>
<tr>
<td>17. I feel most fulfilled when I'm in close communion with God.</td>
<td>242</td>
<td>5.25</td>
<td>1.27</td>
</tr>
<tr>
<td>19. My relation with God contributes to my sense of well-being.</td>
<td>244</td>
<td>5.34</td>
<td>1.26</td>
</tr>
</tbody>
</table>
Table 4—Continued

<table>
<thead>
<tr>
<th>Items</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Existential Well-Being</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I don't know who I am, where I came from, or where I'm going.</td>
<td>244</td>
<td>5.23</td>
<td>1.35</td>
</tr>
<tr>
<td>4. I feel that life is a positive experience.</td>
<td>243</td>
<td>5.30</td>
<td>1.18</td>
</tr>
<tr>
<td>6. I feel unsettled about my future.</td>
<td>245</td>
<td>4.39</td>
<td>1.70</td>
</tr>
<tr>
<td>8. I feel very fulfilled and satisfied with life.</td>
<td>245</td>
<td>4.56</td>
<td>1.36</td>
</tr>
<tr>
<td>10. I feel a sense of well-being about the direction my life is headed in.</td>
<td>241</td>
<td>4.90</td>
<td>1.24</td>
</tr>
<tr>
<td>12. I don't enjoy much about life.</td>
<td>244</td>
<td>4.90</td>
<td>1.48</td>
</tr>
<tr>
<td>14. I feel good about my future.</td>
<td>244</td>
<td>5.17</td>
<td>1.20</td>
</tr>
<tr>
<td>16. I feel that life is full of conflict and unhappiness.</td>
<td>244</td>
<td>3.98</td>
<td>1.68</td>
</tr>
<tr>
<td>18. Life doesn't have much meaning.</td>
<td>243</td>
<td>5.12</td>
<td>1.40</td>
</tr>
<tr>
<td>20. I believe there is some real purpose for my life.</td>
<td>244</td>
<td>5.59</td>
<td>1.00</td>
</tr>
</tbody>
</table>

\( ^a \) Response alternatives range from 1 = Strongly Disagree to 6 = Strongly Agree.

\( ^b \) Items were reverse coded. Response alternatives range from 6 = Strongly Disagree to 1 = Strongly Agree.

---

Table 5

Descriptive Statistics for Acculturation Items

<table>
<thead>
<tr>
<th>Item (^a)</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>With which group(s) of people do you feel you share most of your beliefs and values?</td>
<td>266</td>
<td>3.71</td>
<td>1.89</td>
</tr>
<tr>
<td>With which group(s) of people do you feel you have the most in common?</td>
<td>268</td>
<td>3.08</td>
<td>1.94</td>
</tr>
<tr>
<td>With which group(s) of people do you feel the most comfortable?</td>
<td>268</td>
<td>3.13</td>
<td>2.26</td>
</tr>
<tr>
<td>In your opinion which group(s) of people best understands your ideas (your way of thinking)</td>
<td>268</td>
<td>3.10</td>
<td>2.37</td>
</tr>
<tr>
<td>Which culture(s) do you feel proud to be a part of?</td>
<td>267</td>
<td>2.40</td>
<td>1.94</td>
</tr>
<tr>
<td>In which culture(s) do you know how things are done and feel that you can do them easily?</td>
<td>268</td>
<td>3.39</td>
<td>2.44</td>
</tr>
<tr>
<td>In which culture(s) do you feel confident that you know how to act?</td>
<td>267</td>
<td>3.13</td>
<td>2.24</td>
</tr>
<tr>
<td>In your opinion, which group(s) of people do you understand best?</td>
<td>267</td>
<td>3.05</td>
<td>2.19</td>
</tr>
<tr>
<td>In which culture(s) do you know what is expected of a person in various situations?</td>
<td>265</td>
<td>3.32</td>
<td>2.31</td>
</tr>
<tr>
<td>Which culture(s) do you know the most about history, traditions, and customs, and so forth?</td>
<td>267</td>
<td>2.38</td>
<td>1.96</td>
</tr>
</tbody>
</table>

\( ^a \) Response alternatives range from 1 = Only Kenyan to 9 = Only American.
Internal Consistency Reliability Scores

Table 6 presents the reliability estimates for each of the ATSPPH, SWB, and Psychological Acculturation subscale and total scores. Pallant (2007) recommends the Cronbach alpha coefficient should be above .70. Reliability estimates for the Existential Well-Being and Religious Well-Being subscales were .85 and .88, respectively. Cronbach’s alpha for the total Spiritual Well-Being scale was .90.

Table 6

<table>
<thead>
<tr>
<th>Scale</th>
<th>Cronbach’s Alpha (α)</th>
<th>N Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPPH (Total)</td>
<td>.84</td>
<td>29</td>
</tr>
<tr>
<td>Recognition of Personal Need for Psychological Help</td>
<td>.60</td>
<td>8</td>
</tr>
<tr>
<td>Stigma Tolerance Associated with Psychological Help</td>
<td>.50</td>
<td>5</td>
</tr>
<tr>
<td>Interpersonal Openness Regarding One’s Problems</td>
<td>.63</td>
<td>7</td>
</tr>
<tr>
<td>Confidence in Mental Health Professional</td>
<td>.64</td>
<td>9</td>
</tr>
<tr>
<td>Spiritual Well-Being (Total)</td>
<td>.90</td>
<td>20</td>
</tr>
<tr>
<td>Existential Well-Being</td>
<td>.85</td>
<td>10</td>
</tr>
<tr>
<td>Religious Well-Being</td>
<td>.88</td>
<td>10</td>
</tr>
<tr>
<td>Acculturation</td>
<td>.90</td>
<td>10</td>
</tr>
</tbody>
</table>

Note. Recommended Cronbach alpha is above .70

Research Question 1

A three-way between groups MANOVA was initially conducted to answer question 1, which read as follows: What is the relationship between demographic variables (i.e., gender, education, and marital status) and attitudes toward seeking professional counseling for Kenyan immigrants in the United States? The dependent variables were Recognition of Personal Need for Professional Psychological Help,
Tolerance of the Stigma Associated with Psychological Help, Interpersonal Openness Regarding One’s Problem, and Confidence in the Mental Health Professional. The independent variables were Gender, Education, and Marital Status.

Due to violations of MANOVA assumptions (i.e., equality of variance), as explained below, MANOVA was found to be an inappropriate analysis. A 2 x 4 x 3 factorial ANOVA with gender, education, and marital status as the independent variables and total ATSPPHS as dependent variable was conducted instead.

**Multicollinearity**

According to Pallant (2007), “MANOVA works best when the dependent variables are only moderately correlated. With low correlations, one should consider running separate univariate analysis of variance for your various dependent variables. When the dependent variables are highly correlated, this is referred to as multicollinearity” (p. 282). Correlations between .3 and .7 are generally considered acceptable, while correlations around .8 or .9 are of concern. As shown in Table 7, the correlations among the ATSPPHS subscales are between .36 and .54 and acceptable.

**Table 7**

*Pearson’s Correlations of Dependent Variables*

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recognition of personal need for professional psychological help</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Tolerance of the stigma associated with psychiatric help</td>
<td>.47**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Interpersonal openness regarding one’s problems</td>
<td>.54**</td>
<td>.49**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Confidence in the mental health professional</td>
<td>.53**</td>
<td>.42**</td>
<td>.36**</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Religious well being</td>
<td>.06</td>
<td>-.04</td>
<td>-.03</td>
<td>.07</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>6. Existential well being</td>
<td>-.05</td>
<td>-.04</td>
<td>.09</td>
<td>-.08</td>
<td>.63**</td>
<td>-</td>
</tr>
</tbody>
</table>

*Note.** **Correlation is significant at 0.01 level (2-tailed). * Correlation is significant at 0.05 level (2-tailed).
**Collapsed Variables**

According to Pallant (2007), the number of dependent variables is the minimum number of required cases in each cell. Therefore, Marital Status was collapsed into three categories: Single, Married/Partnered, and Divorced/Widowed/Separated in order to increase the number of cases. Likewise, Education was collapsed into four categories: Less than High School/High School/GED, Some College, Bachelor’s Degree, and Master’s/Doctoral Degree.

**Homogeneity of Variance-Covariance Matrices and Equality of Variance**

Box’s Test of Equality of Covariance Matrices confirmed that the observed covariance matrices of the dependent variables were equal across groups (Box’s $M = 234.95$, $p < .05$). Levene’s Test of Equality of Error Variances indicated that the error variance of the Recognition of Personal Need for Professional Psychological Help ($p = .65$) and Tolerance of the Stigma Associated with Psychological Help ($p = .14$) subscales were equal across groups. The error variance of the Interpersonal Openness Regarding One’s Problem ($p < .001$) and Confidence in the Mental Health Professional ($p < .001$) subscales was not equal across groups, however. This is an indication of inadequate sample size in each cell. Upon reviewing the SPSS output it was determined, in fact, the minimum required number of cases in each cell (in this case 4) was not met. MANOVA requires that there will be at least as many cases in each cell as there are dependent variables (Pallant, 2007). When this occurs it is recommended that the number of dependent variables be combined or reduced. In this case, a combination of dependent variables represents total ATSPPHS scores. Therefore, a $2 \times 4 \times 3$ (Gender x Education x Marital Status) factorial ANOVA was conducted. In the three-way factorial ANOVA,
Levene’s Test of Equality of Error Variances indicated that the error variance was not equal across groups for Total ATSPPHS ($p < .01$) in this design as well. A more stringent significance level of .01 was therefore used instead (Pallant, 2007).

**Results**

Figures 2 through 4 present comparisons of mean total ATSPPHS for gender, education, and marital status. As shown in Figure 2, there were no statistically significant differences in the mean for Gender ($F(1, 199) = .71$, $p = .40$, partial eta squared = .004) between male ($M = 53.45$) and female ($M = 54.77$) participants.

*Figure 2. Mean total ATSPPHS for gender. Female = 54.77, Male = 53.45.*
As shown in Figure 3 there were no statistically significant differences in the mean for Education ($F(3, 199) = 1.72, p = .16$ partial eta squared $= .025$) among participants with Less than High School/High School/GED ($M = 50.58$), Some College ($M = 52.19$), Bachelor’s Degree ($M = 55.22$), and Master’s/Doctoral ($M = 56.48$) levels of education.

Figure 3. Mean total ATSPPHS for education. Less than High School/High School/GED $= 50.58$, Some College $= 52.19$, Bachelor’s Degree $= 55.22$, Master’s/Doctoral $= 56.48$. 
As shown in Figure 4 there were no statistically significant differences in the mean for Marital Status ($F(2, 199) = .98, p = .38$, partial eta squared $= .010$) among Single ($M = 54.81$), Married/Partnered ($M = 54.44$), and Divorced/Widowed/Separated ($M = 51.37$) participants.

![Figure 4. Mean total ATSPPHS for marital status. Single = 54.81, Married/Partnered = 54.44, Divorced/Widowed/Separated = 51.37.](image)

A 2 (Gender) x 4 (Education) x 3 (Marital Status) factorial ANOVA was conducted to explore the impact of gender, education and marital status on attitude toward professional psychological help seeking. Participants were divided into two groups according to their gender (Male, Female), four groups according to their level of
education (Less than High School/High School/GED, Some College, Bachelor’s Degree, and Master’s/Doctoral Degree), and three groups according to their marital status (Single, Married/Partnered, and Divorced/Widowed/Separated). The main effects for gender ($F(1, 199) = .71, p = .40$, partial eta squared = .004), education ($F(3, 199) = 1.72, p = .16$, partial eta squared = .025), and marital status ($F(2, 199) = .98, p = .38$, partial eta squared = .010) were not statistically significant. The interaction effects for education, marital status, and gender ($F(6, 199) = .72, p = .63$, partial eta squared = .021); marital status and gender ($F(2, 199) = 0.16, p = .85$, partial eta squared = .002); education and gender ($F(3, 199) = 1.65, p = .18$, partial eta squared = .024); and education and marital status ($F(6, 199) = 2.60, p = .02$, partial eta squared = .072) were not statistically significant. Thus, it appears neither gender, education, nor marital status has any statistically significant effect on attitudes toward professional psychological help.

**Research Question 2**

General linear multiple regression analysis was used to answer research question 2, which read as follows: What is the relationship between spiritual well-being, level of acculturation, and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States? The dependent variable was Total ATSPPHS. The independent variables were Total SWB and Psychological Acculturation.

**Multicollinearity**

Prior to interpreting results from the general linear multiple regression collinearity diagnostics were examined to determine any issues related to multicollinearity (Pallant, 2007). First correlations between the independent and dependent variables were examined. Pallant (2007) recommends a correlation of between .3 and .7. The correlation
between Total SWB and Total ATSPPHS was .03, while the correlation between Psychological Acculturation and Total ATSPPHS was .09. The Tolerance value (.99), however, was acceptable, as was the Variance Inflation Factor (1.01).

**Normal Probability Plot of the Regression Standardized Residual and Scatterplot**

Normality, linearity, and homoscedasticity are all assumptions of multiple regression (Pallant, 2007). As shown in Figure 5, the points on the diagonal line are reasonably straight, which suggests no major deviations from normality. Figure 6 shows the presence of outliers which are defined as standardized residual of more than 3.3 or less than -3.3 (Pallant, 2007) as shown in the figure, there are no outliers outside this range.

*Figure 5. Normal probability plots of the regression standardized residual.*
Figure 6. Scatter plot of standardized residuals.

Results

General linear multiple regression showed that Total SWB and Psychological Acculturation did not have a statistically significant influence on Total ATSPPHS ($F(2, 207) = .98, p = .38$). See Table 8.

Table 8

Summary of Regression Analysis for Total SWB, Acculturation, and Total ATSPPHS

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>95.0% Confidence Interval for B</th>
<th>Correlations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td>t</td>
</tr>
<tr>
<td>1 (Constant)</td>
<td>48.68</td>
<td>6.28</td>
<td></td>
<td>7.75</td>
</tr>
<tr>
<td>Acculturation</td>
<td>.08</td>
<td>.06</td>
<td>.09</td>
<td>1.35</td>
</tr>
<tr>
<td>Total SWB</td>
<td>.03</td>
<td>.06</td>
<td>.04</td>
<td>.52</td>
</tr>
</tbody>
</table>
Summary of Results

Hypothesis 1

Hypothesis 1 was: There is a statistically significant relationship between gender, education, and marital status and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States. According to the results of the three-way factorial ANOVA, there are no statistically significant differences in attitudes toward seeking professional psychological help based on gender, education, or marital status.

Hypothesis 2

Hypothesis 2 was: There is a statistically significant relationship between spiritual well-being, acculturation, and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States. The results of general linear multiple regression showed that spiritual well-being and acculturation did not have a statistically significant influence on attitudes toward seeking professional psychological help for Kenyan immigrants in the United States.
CHAPTER V

DISCUSSION AND IMPLICATIONS

The purpose of this study was to investigate the attitudes toward seeking professional psychological help among Kenyan immigrants living in the United States. The study examined the relationship between demographic variables (i.e., marital status, age, income, gender, length of stay in the United States, level of education, level of psychological acculturation) and attitudes toward seeking professional psychological help for Kenyan immigrants in the United States. Additionally, the study examined the relationship between spiritual well-being, level of psychological acculturation, and attitudes toward seeking professional psychological help.

The findings of this study are presented in reference to previous research and literature. The chapter consists of the following sections: overview of the study, discussion of major findings, implications for theory and practice, limitations of the study, recommendations for future research, and concluding remarks.

Overview of the Study

Kenyan immigrants, though an invisible minority in the U.S. population, represents a rapidly expanding group of African immigrants in the United States. Increasing immigration of Africans to the United States has revealed a lack of knowledge about their health needs and practices. It is also noted that health concerns are poorly characterized among African immigrants (Venters et al., 2011). Kenyan immigrants have experienced long standing deleterious life events in their home nation (e.g., interethnic violence, terrorist attacks) and may vicariously suffer additional stressors as they seek to pursue their life long goals in the United States. Nwadiora (1996) identified
psychological loss of identity, loss of extended families, familial environment, dietary changes, and other social cultural mores, which are at the core of problems with African families.

In this study, demographic variables (i.e., gender, education, and marital status) were examined as it relates to attitudes toward seeking professional psychological counseling for Kenya immigrants. The study also examined the relationship between spiritual well-being, level of acculturation, and attitudes toward seeking professional psychological help. It was hypothesized that: (a) There would be a statistically significant relationship between gender, education, marital status, and attitudes toward seeking professional psychological help, and (b) There is a statistically significant relationship between spiritual well-being, acculturation, and attitudes toward seeking professional psychological help. Data was collected by paper and pencil from designated Kenyan Community Churches in Midwestern and Central States, as well as online data through Mwakilishi.com, an online newsletter for Kenyans in diaspora. Additional data was solicited from Kenya Scholars and Studies Association (KESSA), which is accessed by Kenyan scholars in higher education in the United States.

**Discussion of the Results**

The findings of the study can be used for further understanding of Kenyan immigrants’ attitudes toward seeking professional psychological help, level of psychological acculturation, and their spiritual well-being. The discussion of the findings includes a section related to demographic characteristics of the participants followed by two sections based upon the results of the research questions.
Demographic Characteristics

There was equal gender participation, indicating that men (50.2%) and women (49%) were evenly willing to participate in the study. The results from the study revealed that only 38 (14%) reported previous consultation with a mental health professional and 227 (81%) of the participants had not. Similarly, only a quarter \( (n = 73; 27\%) \) reported previous consultation with a spiritual leader, and almost three quarters \( (n = 193; 73\%) \) of the participants had no previous consultation. The mean score for confidence in the mental health professional was 10.20 \( (SD = 2.92) \), indicating a low confidence, and 9.14, \( (SD = 3.19) \) for tolerance of the stigma associated with psychiatric help, indicating high stigma in the attitude toward seeking professional help scale. Despite scoring \( (M = 14.21, SD = 4.46) \) reflecting the recognition of personal need for professional psychological help, only 14% reported previous consultation with a mental health professional.

A possible explanation for this result is supported by explanatory models that describe and interpret mental illness from a spiritual perspective, indicating Kenyan immigrants are likely to seek help from spiritual leaders who are easily accessible. Furthermore, there is scarcity of professional mental health specialists. Kenyan immigrants’ unfamiliarity with and unavailability of professional counseling in their country of origin, therefore, may explain their perceived lack of basic knowledge of how to access and navigate mental health services in the United States. As previously noted in the literature, the Kenya health system is dominated by psychiatrists who provide mental health from a medical model through the use of medication. Psychiatrists may be shunned due to their association with the Mathari Mental Hospital in Nairobi and the stigma related with psychiatric treatment.
Previous studies on barriers to health care access reveal a plethora of structural barriers faced by black immigrants in the United States that may be mitigated with certain moderators (e.g., intention, perceived benefits, and health literacy). Specifically, research has found that black immigrants who have the intention of accessing health care, perceive the benefits of the health care, and have health literacy are more likely to actually access health care when compared to black immigrants who do not exhibit these moderating factors (Wafula & Snipes, 2014). This is especially important when considered within the context of the findings of the current study, which indicate that only 14% of participants had sought consultation with a mental health professional. A research conducted by Othieno (2007) indicates that ethnic migrants from sub-Saharan Africa face barriers to health care access which may include distorted views about health care, fear and lack of information concerning the health care system and services offered, stigma, cultural and religious beliefs not understood by clinicians, and gender norms.

A majority of participants self-reported as affiliated to an organized religious faith. One hundred twenty-four (46%) attended weekly worship services, with 84 (32%) attending at least twice every month. Consequently, in this study, 54 (19%) of the participants would prefer to consult with ministerial clergy or a spiritual leader as their first choice when having a psychological problem. A possible explanation for this phenomena may be due to participants’ familiarity with their spiritual leaders; hence, increasing the trust conferred to the spiritual leader. The spiritual leaders in this research study were Kenyan immigrants who shared similar experiences and unique immigration challenges with research participants. They were easily accessible among immigrants as
opposed to other professionals offered in the questionnaire (i.e., psychologists, counselors, physicians, psychiatrists).

Preferring to consult with ministerial clergy or spiritual leaders was followed by preferring to consult with a trusted friend \( n = 50; 18\% \), consulting with family \( n = 45; 16\% \), and consulting with a professional counselor/therapist \( n = 32; 12\% \). Preference for a respected elder tied with a psychologist \( n = 13; 5\% \). It is important to note that only two \( 0.7\% \) of the participants would prefer to consult with a psychiatrist, while 16 \( 5.7\% \) would prefer not to seek help.

The above finding support similar studies regarding the non-utilization of professional mental health services among African Americans. Specifically, this finding is consistent with a content analysis of studies that revealed a preference for ministerial support among African Americans. The focus group revealed that for African Americans, ministers often serve as an alternative to mainstream mental health providers. Moreover, African American clergy report being more involved in counseling work than do clergy of other ethnic backgrounds. The plethora of issues taken to clergy include: (a) physical health problems including hospitalizations, (b) interpersonal difficulties (e.g., marital problems), (c) emotional adjustment problems, (d) death of loved ones and grief and bereavement, (e) family problems, (f) romantic relations, (g) reproductive and fertility issues, and (h) financial-work related issues (Mollica, Streets, Bocarino, & Redlick, 1986; Young et al., 2003, as cited in Mattis et al., 2007). Although Kenyan immigrants were not asked to identify specific issues they would address in the event of seeking help, they are likely to identify with the daily stressors and distressing negative life events discussed in the focus group conducted in the mentioned research study.
As stated, the present study revealed that only a negligible amount (0.7%) of participants would prefer to consult with a psychiatrist compared to clergy (19%) for a psychological need. This indicates clergy and pastors hold an influential, unifying, and visible position within the immigrant population. The clergy-psychiatry polarity may better be explained from a cultural-historical viewpoint. Culturally, the modern clergy may have replaced the critical position and function of the traditional medicine man. For instance, Crawford (1909) conducted anthropological studies of the Kikuyu medicine man and found that, as in many African cultures, the medicine man integrated the function of prophet, priest, and physician, and played active roles in the religious and social functions of the people. As a traditional practitioner, the medicine man was frequently consulted and followed, therefore, exerting a powerful and authoritative influence over the people. The medicine man was known to provide a holistic approach to treatment, addressing the spiritual, physical, and psychological needs of the people. As Twumasi (1972) argued about the significance of the medicine man, “beliefs are held and remedies accepted not on the basis of experimental evidence but on the authority of respected members of the community who have had the experience” (p. 62).

There are fundamental differences of opinion regarding the treatment approaches of traditional African practitioners such as medicine men and modern treatment modalities. The advent of Western medicine and modern treatment approaches may have introduced fragmented and specialist models of treatment, which were unfamiliar to African people and therefore disruptive to the familiar mode of treatment. In essence, many Africans may be unfamiliar with formal and professional treatment methods, which are likely to rely on medication and lack the spiritual dimension as an aspect of treatment.
To conclude, essentially, one of this study’s significant contributions is the revelation that a significant segment of participants first preferred informal relationships and support systems over seeking help from formal professionals. This seems to add credence to Edwards, Makunga, Ngcobo, and Dhlomo’s (2004) assertion of the Ubuntu principle of promoting health that is concerned with giving, receiving and sharing care, support, companionship, help, and healing. The Ubuntu ethic is summed up as *umuntu umuntu ngabantu*, a person is a person through others, or “I am because we are” (Mbiti, 1970). This argument may serve to explain the reason why Kenyan immigrants prefer to seek help from social and family supports and encourage a life of interdependence as opposed to individualism.

It is important to address the significant percentage of participants (6%) who preferred to seek help from no one. Explanation for this outcome may lie in various coping strategies that include stoicism, fatalism, and the perception of help seeking as a sign of weakness and futility. As previously noted in the literature, maintaining supportive and expressive relationships with significant others, storytelling, use of didactic African proverbs, metaphors, folklore, and music are considered important coping skills among Africans. Moreover, the majority of participants in this study were Christians and therefore likely to anchor their mindset with other forms of self-care strategies such as maintaining a vertical relationship with the divine power through prayer, reading of sacred texts, praise, and worship, among others.

**Research Question 1**

Research question 1 explored the relationship between demographic variables (i.e., gender, education, and marital status) and attitudes toward seeking professional
counseling for Kenyan immigrants living in the United States. It was hypothesized that
gender, education, and marital status would have a statistically significant relationship
with attitudes toward seeking professional psychological help. Contrary to the study
hypothesis, this study revealed that neither gender nor education, nor marital status has
any statistically significant effect on attitudes toward professional psychological help.

The finding regarding gender is consistent with findings from a previous study by
Okafor (2009) that examined the effects of demographic variables such as social
economic status, sex, and duration of stay on attitudes toward seeking psychological
professional help among adult Nigerian immigrants in the United States. The effect of the
three demographic variables had no statistically significant effect on general attitudes, but
did have a statistically significant effect on the need and openness attitudes of Nigerian
immigrants. Other researchers have found that women exhibit more positive attitudes
toward help seeking than men, and statistically significant interactions have been found
between age and marital status, and between gender and education. Mackenzie, Gekoski,
and Knox (2006) also found that women exhibited more positive attitudes and openness
to seek psychological help.

In contrast, Akinsulure-Smith et al. (2013) found that seeking formal services is a
last resort for women, and many immigrants discontinue services due to shame and
stigma when their help seeking becomes known. Comparatively, in a similar study of
female Jordanian, United Arab Emirates (UAE), and Arab immigrant students in Israel,
marital status and age were found to be significant predictors of positive attitudes toward
seeking help (Al-Krenawi-Graham, Dean, & Eltaiba, 2004). Furthermore, the researchers
also found that single women had less positive attitudes to seeking professional help than
married women. Another study by Leaf et al. (1988) concurred that predisposing factors such as marital status or age are contingent upon the need to seek mental health services.

A meta-analysis of gender differences in attitudes toward professional psychological help seeking behavior suggests gender differences could be affected by other cultural factors such as race. In their generalized samples of college students, several researchers found contradictory results depending on individuals’ cultural background. For instance, there was considerable consistency among Caucasian students in a study comprising 70 men and 186 women (Achter, 1995); another study of 124 men and 186 women, of which 87% identified as Caucasian (Komiya et al., 2000); and an additional study of 154 male and 136 female undergraduates (Leong & Zachar, 1999), which indicated that gender was significant in help seeking attitudes. Conversely, gender was not significant among 92 male and 78 female (Zang & Dixon, 2003) and 206 male and 394 female (Masuda et al., 2005) undergraduate Asian students.

As it relates to education, it is well noted that the participants in the present study reported high levels of post-secondary education \( (n = 84, 30\%) \), some college \( (n = 85, 31\%) \), a bachelor’s degree \( (n = 67, 24\%) \), and a master’s or doctoral degree \( (n = 16, 6\%) \). Data indicated high educational attainment among participants, but low acculturation levels. Contrary to initial expectations, education as a variable had no statistically significant effect on attitudes toward professional psychological help. The result regarding level of education as a variable is consistent with the findings of Okafor (2009), Fung and Wong (2007), and Tang, Kim, Hansen, and Chiriboga (2007) who also did not find education to be a predictor of willingness to seek psychological help. However, other researchers found that participants who were older and better educated
exhibited a greater propensity to seek psychological help (Mackenzie et al., 2006). Women had positive help-seeking attitudes regardless of how well educated they were. In contrast, higher levels of education positively influenced men’s attitudes.

Lastly, concerning marital status, a prior study found that single, older participants exhibited positive attitudes toward psychological help seeking, consistent with the fact that never-married individuals are more likely than married individuals to seek help from mental health professionals (Kessler et al., 2005). This is different than the findings of this study, which indicate no statistically significant relationship between marital status and attitudes toward seeking professional help.

**Research Question 2**

Research question 2 explored the relationship between spiritual well-being, level of acculturation, and attitudes toward seeking professional psychological help for Kenyan immigrants living in the United States. In comparison with other research studies, there is a dearth of empirical research on Kenyan immigrants’ spiritual well-being, level of acculturation, and help seeking attitudes. In this present study, a general linear multiple regression analysis was performed in order to determine if the relationships between the variables were statistically significant. The current study shows total spiritual well-being and level of acculturation did not have a statistically significant influence on total scores from the Attitudes Toward Professional Psychological Help Scale (ATPPHS); that is, participants’ spiritual well-being, as measured by the SWB scale, and level of acculturation did not positively impact attitudes to seek professional counseling.

It should be noted that participants in this study reported high religiosity level on Total Spiritual Well-Being Scale ($M = 101.3$, $SD = 16.7$), reflecting a sense of high
spiritual well-being (on a scale that ranges from Low $M = 20$ to 40; Moderate $M = 41$ to 99; and High $M = 100$ to 120). The majority of participants also reported weekly religious participation for seeking fellowship and spiritual nurture. Additionally, higher scores were reported on the Religious Well-Being subscale (RWB) ($M = 51.90$, $SD = 9.70$, highest possible score 60) and Existential Well-Being subscale (EWB) ($M = 49.10$, $SD = 8.92$, highest possible score 60), suggesting a high level of satisfaction with their life and a clear sense of purpose. On average, the results obtained in this study compare well with those reported by the conservative American Baptist religious group sample score among other religious groups included and measured by the Spiritual Well-Being Scale (Paloutzian & Ellison, 1991).

The review of literature in this study highlighted the high regard for religiosity and spirituality among Africans. Ellison and Smith (1991) studied the relationship between religious involvement and subjective well-being and found that among those with strong religious faith, involvement in church attendance and activities resulted in higher levels of life satisfaction. Furthermore, strong religious faith seemed to indicate improved well-being in at least four ways: (1) providing support and a form of social integration, (2) providing systems of meaning and existential coherence, (3) religious organization giving order to one’s personal lifestyle, and (4) enhancing psychological well-being by establishing a personal relationship with a divine order.

Gartner (1996) also found positive associations between religion-spirituality and well-being, marital satisfaction, and general psychological functioning; specifically, suicide, delinquency, criminal behavior, and drug and alcohol use (Gartner, 1996 as cited in Seybold & Hill, 2001). Hill and Butter (1995) discussed the protective effects of
religion and found that religion and spirituality has beneficial effects on health via social networks. Also religious and spiritual communities provide opportunities for fellowship, involvement in formal social programs and that this kind of support can have beneficial effects by reducing both psychological and physical stressors (Seybold & Hill, 2001).

The fact that the participants in this study had high levels of spiritual well-being, which suggests as the literature indicates better overall psychological functioning, may have led to more neutral attitudes toward seeking professional help.

**Implications for Theory and Practice**

In this present study, spirituality emerged as an important positive variable, reporting high levels on spiritual well-being. A large group of participants reported they attend church weekly (46%) or at least once or twice a month (32%). As discussed earlier in the literature review and supported by the results of this study, spirituality and expressive worship feature prominently among African immigrants’ religious experience in the United States. Members of minority ethnic groups tend to have high regard for religious beliefs, a factor contributing to a sense of hope and optimism, meaning, and purpose in life and better mental health (Olupona & Gemignani, 2007). This may help bring a better understanding of the lower likelihood of Africans and especially Kenyan immigrants seeking professional help found in other studies, although there was no statistically significant relationship found in this study. It is also likely that Kenyans utilize and seek alternative methods of coping in participating in religious activities such as finding spiritual renewal and strength in the sacred texts, praise, and worship, and are drawn to seek spiritual help in accordance with the African tendency to uphold the practice of worship and interpret psychosocial problems from a spiritual standpoint.
Therefore, counseling modalities that are grounded on Western humanistic theories that fail to resonate with aspects of faith and spirituality may be alien to most African and Kenyan immigrants.

The implication for counseling theory is that professional counseling, which has its foundation in the Western approach, reflects a culture-bound, mono-cultural in perspective may be unappealing to African immigrants. There are fundamental and philosophical differences between African and Eurocentric worldviews. For instance, in psychoanalytic theory, emotional insight is of immense therapeutic significance (McWilliams, 1999), which draws much from an idealization of understanding as the primary route to emotional health. Therefore, in case conceptualization, healing becomes possible by “making conscious what had been unconscious,” noting that “know thyself” pervades most psychoanalytic thinking (McWilliams, 1999). In contrast, the African understanding of mental health has a spiritual significance. As noted earlier in this study, mental health problems, suffering, misfortune, disease, and accidents are believed to be caused mystically and attributed to supernatural powers. Healing, therefore is possible through prophesy, purification, divination, and the cursing of sickness, which may somehow possibly explain one of the reasons Kenyan immigrants gravitating toward a spiritual leader over professional practitioners.

In counseling, there has been an increase in cognitive-behavioral therapy (CBT) practice and research. A survey of 2,000 practitioners (counselors, social workers, psychologists) found that approximately 69% use CBT counseling methods (Psychotherapy Networker, 2002), and another poll of practicing psychologists found that 89% of 470 respondents used CBT (Meyers, 2006). CBT has been considered to be
value-neutral. However, its theory is supported by a dominant culture that embraces assertiveness, personal independence, verbal ability, rationality, cognition, and behavioral change. This seems to contradict the African collective worldview, which 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).

It is also noted that CBT has an individualistic orientation and emphasis on cognitive restructuring to the neglect of environmental intervention (Hays, 2009). In contrast, Mbiti (1999) asserts that in traditional life:

the African individual does not and cannot exist alone except corporately. The community, therefore makes, creates and produce the individual; for the individual depends on the corporate group. Additionally, to be human is to belong to the whole community, which involves participating in the beliefs, ceremonies, ritual and festivals of the community. To be without religion amounts to a self-excommunication from the entire life of societies. (Mbiti, 1999, p. 108)

It is, therefore, incumbent for professional counselors to explore during the assessment process the extent of influence the African worldview has on Kenyan immigrant clients. The ideals of Ubuntu-ism (i.e., principles of collectiveness, interdependence, and interpersonal relationship) need to be explored in the treatment of Kenyan immigrants living in the United States. For instance, researchers found that
maintenance of ethnic identity is generally related to psychological well-being among members of acculturating groups (Phinney, Horenczyk, Liebkind, & Vedder, 2001).

There were more respondents (27%) who had previous consultation with a spiritual leader than a mental health professional (14%), which suggests that Kenyans have more trust in spiritual leaders than mental health professionals. In the event of counseling Kenyan immigrants, practitioners need to have the knowledge and awareness of the subtle barriers associated with stigma. It should be noted that Kenyan immigrant status comes with much responsibility, prestige, and expectations for success. For instance, a Kenyan immigrant may assume the multiple roles of being a student, supporting their families back home in Kenya, and being under pressure to be financially successful. In spite of the fact that a Kenyan immigrant may live with unrealistic expectations and likely to experience mental health challenges, help seeking may be viewed as a sign of admitting to one’s weaknesses and failure to succeed in the United States, a land associated with vast opportunities. Kenyan immigrants may not want to be labeled or stigmatized as struggling with mental health problems. This may therefore delay help-seeking for immigrants who live with severe mental health concerns. It is important for counselor educators to work collaboratively with spiritual leaders and play supportive roles in reaching out and providing psycho-educational and needs-based seminars in places of worship and other centers of influence. Thus, the counselor education profession is uniquely suited to have impact on reducing stigma associated with counseling and mental illness.
Limitations

This study revealed that the majority of participants (62%) were married and highly educated, with only 16% with high school or less of education. The sample was drawn from Kenyan community churches and majority identified with the mainstream Judeo-Christian faith. Since most Kenyans generally gather in churches for social support and spiritual nurture, it is likely that most Kenyans self-identified with the Christian faith. Nevertheless, single Kenyan immigrants with less education or from different religious faiths may have responded to questions differently.

This researcher made every effort to minimize social desirability in collecting data from churches. Participants may be influenced to respond favorably to questions that have spirituality themes, and negatively to issues pertaining to how they perceive mental health. Results indicated A vast majority reported no prior consultation with a spiritual leader (72.6%) or mental health professional (81.5%). It is therefore evident that the subject of the study and process of seeking help was unfamiliar to most participants, which may have influenced the overall outcome of their attitudes toward seeking professional help.

Although the majority (60.6%) identified with rural and 38.7% from urban geographic regions of birth in Kenya, there was no clear definition of what entailed geographic region of birth the rural and urban choices provided in the demographic questionnaire section. Also, participants were not required to state how long one had lived in the identified geographical regions. There is need for further exploration of how these factors contribute to building a sense of community and supportive network.
Some data was collected online through the use of an electronic module posted on the Kenya Scholars and Studies Association (KESSA), which is accessed by Kenyan scholars in higher education in the United States, and Mwikilishi.com, a Kenyan diaspora newspaper that specified inclusionary criteria to participate (i.e. must be currently living in the United States). There were no incentives for participation, therefore, this researcher expected little or no interference from participants who do not meet inclusionary criteria. Although there was no evidence of external interference from participants outside the United States, the links may have been accessible to other Kenyans living outside the United States. Future studies should be cautious in using such an online module while collecting data within the United States.

Data were collected prior to the recent heightened political discourse that included perceived threats to deport undocumented immigrants living in the United States (Reilly, 2016). Further studies may be necessary to find out how the current immigration narrative in the United States continues to impact or influence spiritual well-being, the acculturation process, and help seeking attitudes.

Heppner, Kivlighan, and Wampold (1999) argued that the level of inquiry in quantitative research tends to be reductionistic-atomistic in the process of understanding a phenomena of a complex subject. Issues of acculturation and spirituality and some other factors that are not necessarily addressed in this study impact the Kenyan immigrants in the United States. Religion, spirituality, attitudes are abstract concepts that can be difficult to define and measure. Also, participants were not able to provide feedback on how they make meaning regarding their lived experiences in the United States. This
researcher recognizes the fact that the study may be affected by unconscious actions during the process of gathering data (Heppner et al., 1999).

Despite the validity and reliability of researched instruments, the Psychological Acculturation Scale (PAS) was adapted from Puerto Rican immigrants. The questions may have not given consideration to the cultural differences and unique challenges and interest of Kenyan immigrants, and may not have asked core questions that are germane among Kenyan immigrants. Furthermore, majority of participants identified as married, suggesting family and social support, while the ATSPPHS was normed with mainly college single students with less family support.

Finally, there is a dearth of literature and research focusing on the help seeking attitudes of the Kenyan population and Kenyan immigrants in the United States. Therefore, this researcher lacked existing empirical data to adequately compare the results from the current study.

**Recommendation for Future Research**

Future research may want to focus on several areas. First, there is need for a qualitative study on this topic focusing on a phenomenological inquiry to gain a deeper understanding of Kenyan immigrants’ lived experiences. This may give a voice and clarify how they respond and negotiate anticipated and unanticipated transitions and the acculturation process; address mental health concerns and help-seeking attitudes, spiritual well-being, coping styles, and resilience; and make meaning to their experiences. Second, research may want to focus on variables that identify symptoms and problem severity and intention to seek help, and find out how they may correlate with help seeking attitudes. Third, there may be a need to further investigate theoretical interventions consistent with
more post-modern theoretical approaches that resonate for marginalized populations. This may provide opportunities to construct specific test instruments that resonate with Kenyans’ conceptualization of mental health and spiritual well-being. Finally, there is a need to know how or whether spiritual leaders address issues of mental health with worshipers, and how professional counselors may collaboratively work with spiritual leaders to provide psycho-education and sustainable programs such as needs-based support groups.

**Conclusion**

The purpose of this study was first to examine the relationship between demographic variables (i.e., marital status, age, income, gender, length of stay, level of education, level of acculturation, and attitudes toward seeking professional psychological counseling) for Kenyan immigrants in the United States. Second, this study also sought to examine the relationship between spiritual well-being, level of psychological acculturation, and attitudes toward seeking professional psychological help. The results of this study did not show any statistically significant relationships between the demographic variables explored and attitudes toward seeking professional psychological help, and spiritual well-being and acculturation were not statistically significant predictors of attitudes toward spiritual well-being. Nevertheless, the participants in this study did show high levels of spiritual well-being according to the Spiritual Well-Being Scale and the majority of participants attended service regularly, weekly or at least twice a month. This indicates that the population of Kenyan immigrants explored in this study has a deep sense of spirituality that may be relevant to the counseling process given differences in the African worldview and conceptions of spirituality and healing.
In consideration of the high levels of spirituality within the Kenyan immigrant population, counselors and counselor educators may want to consider ways they can integrate spirituality and the African worldview into the counseling process. Additionally, they may also want to consider collaborating with clergy to explore mental health issues and the benefit of professional counseling, given the unique mental health needs among this population. Further studies on this topic are in critical need given that the Kenya immigrant population may continue to grow in the United States. These studies may add to the body of knowledge and help in further understanding of the Kenyan population’s attitudes toward seeking professional help.
REFERENCES


http://web.engr.oregonstate.edu/~funkk/Personal/worldview.html


Appendix A

Demographic Questionnaire
Demographic Questionnaire

1. Gender (check one):
   - Female
   - Male

2. Please indicate your age:
   - 18-24
   - 25-34
   - 35-44
   - 45-54
   - 55-64
   - 65 or older

3. Legal marital status (check one):
   - Single
   - Married
   - Partnered
   - Divorced
   - Widowed
   - Separated

4. Please indicate your approximate annual income in U.S. dollars:
   - Less than 15,000
   - 15,001-25,000
   - 25,001-40,000
   - 40,001-55,000
   - 55,001-70,000
   - 70,001-85,000
   - Over 85,001

5. Highest education earned (check one):
   - Less than high school
   - High school/GED
   - Some College
   - Bachelor’s degree
   - Master’s degree
   - Doctoral/professional degree

6. Geographic region of birth (check the response that best describes you):
   - I was born and raised in the rural area in Kenya
   - I was born and raised in the urban area in Kenya

7. Age at the time of migration to the United States:
   - 18-24
   - 25-34
   - 35-44
   - 45-54
   - 55-64
   - 65 or older

8. Number of years lived in the United States:
   - Less than 1 year
   - 2-5
   - 6-10
   - 11-15
   - 16-20
   - Over 20
9. With which group(s) of people do you feel you share most of your beliefs and values?

1  2  3  4  5  6  7  8  9

only Kenyan

10. With which group(s) of people do you feel you have the most in common?

1  2  3  4  5  6  7  8  9

only Kenyan

11. With which group(s) of people do you feel the most comfortable?

1  2  3  4  5  6  7  8  9

only Kenyan

12. In your opinion which group(s) of people best understands your ideas (your way of thinking)?

1  2  3  4  5  6  7  8  9

only Kenyan

13. Which culture(s) do you feel proud to be a part of?

1  2  3  4  5  6  7  8  9

only Kenyan

14. In which culture(s) do you know how things are done and feel that you can do them easily?

1  2  3  4  5  6  7  8  9

only Kenyan
15. In which culture(s) do you feel confident that you know how to act?
   1  2  3  4  5  6  7  8  9
   only Kenyan
   only American

16. In your opinion, which group(s) of people do you understand best?
   1  2  3  4  5  6  7  8  9
   only Kenyan
   only American

17. In which culture(s) do you know what is expected of a person in various situations?
   1  2  3  4  5  6  7  8  9
   only Kenyan
   only American

18. Which culture(s) do you know the most about history, traditions, and customs, and so forth?

19. With what religious denomination are you primarily affiliated?

☐ Anglican Church of Kenya  ☐ Pentecostal
☐ African Inland Church  ☐ Seventh Day Adventist
☐ Roman Catholic  ☐ Traditionalist
☐ Methodist  ☐ Non-denominational
☐ Presbyterian  ☐ Other _______________

20. How often do you attend worship service?

☐ At least once a week  ☐ At least 1-2 times a month
☐ At least 3-4 times a month  ☐ Never

21. Have you ever consulted a spiritual leader for psychological or emotional problem?

☐ Yes  ☐ No
22. Have you ever consulted a mental health professional for psychological or emotional problem?

☐ Yes  ☐ No

23. Who would you consult with if you experienced a psychological or emotional problem?

☐ Clergy/Pastor  ☐ Physician  ☐ Respected Elder

☐ Counselor/Therapist  ☐ Psychiatrist  ☐ Trusted Friend

☐ Family  ☐ Psychologist  ☐ No one
Appendix B

Attitudes Toward Seeking Professional Help Scale (ATSPHS)
Attitudes Toward Seeking Professional Help Scale (ATSPHS)

For each statement, please indicate the choice that best indicates the extent of your agreement or disagreement using the following scale:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Moderately Disagree</td>
<td>Moderately Agree</td>
<td>Agree</td>
</tr>
</tbody>
</table>

1. Although there are clinics for people with mental troubles, I would not have much faith in them.
   0 1 2 3

2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.
   0 1 2 3

3. I would feel uneasy going to a psychiatrist because of what some people would think
   0 1 2 3

4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.
   0 1 2 3

5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.
   0 1 2 3

6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
   0 1 2 3

7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
   0 1 2 3

8. I would rather live with certain mental conflict than go through the ordeal of getting psychiatric treatment.
   0 1 2 3
9. Emotional difficulties, like many things, tend to work out by themselves.

0 1 2 3

10. There are certain problems which should not be discussed outside of one’s immediate family.

0 1 2 3

11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.

0 1 2 3

12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

0 1 2 3

13. Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns.

0 1 2 3

14. Having been a psychiatric patient is a blot on a person’s life.

0 1 2 3

15. I would rather be advised by a close friend than a psychologist, even for an emotional problem.

0 1 2 3

16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.

0 1 2 3

17. I resent a person—professionally trained or not—who wants to know about my personal difficulties.

0 1 2 3

18. I would want to get psychiatric attention if I was worried or upset for a long period of time.

0 1 2 3
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

20. Having been mentally ill carries with it a burden of shame.

21. There are experiences in my life I would not discuss with anyone.

22. It is probably best not to know everything about oneself.

23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.

25. At some future time I might want to have psychological counseling.

26. A person should work out his own problems; getting psychological counseling would be a last resort.

27. Had I received treatment in a mental hospital, I would not feel that it ought to be “covered up.”

28. If I thought I needed psychiatric help, I would get it no matter who knew about.
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.
Appendix C

Spiritual Well-Being Scale
Spiritual Well-Being Scale

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree
MA = Moderately Agree
A = Agree
D = Disagree
MD = Moderately Disagree
SD = Strongly Disagree

1. I don’t find much satisfaction in private prayer with God
   SA  MA  A  D  MD  SD

2. I don’t know who I am, where I came from, or where I am going.
   SA  MA  A  D  MD  SD

3. I believe that God loves me and cares about me.
   SA  MA  A  D  MD  SD

4. I feel that life is a positive experience.
   SA  MA  A  D  MD  SD

5. I believe that God is impersonal and not interested in my daily situations.
   SA  MA  A  D  MD  SD

6. I feel unsettled about my future.
   SA  MA  A  D  MD  SD

7. I have a personally meaningful relationship with God.
   SA  MA  A  D  MD  SD

8. I feel very fulfilled and satisfied with life.
   SA  MA  A  D  MD  SD

9. I don’t get much personal strength and support from my God.
   SA  MA  A  D  MD  SD

10. I feel a sense of well-being about the direction my life is headed in.
    SA  MA  A  D  MD  SD

11. I believe that God is concerned about my problems.
    SA  MA  A  D  MD  SD

12. I don’t enjoy much about life.
    SA  MA  A  D  MD  SD

13. I don’t have a personally satisfying relationship with God.
    SA  MA  A  D  MD  SD

    SA  MA  A  D  MD  SD

15. My relationship with God helps me not to feel lonely.
    SA  MA  A  D  MD  SD

16. I feel that life is full of conflict and unhappiness.
    SA  MA  A  D  MD  SD

17. I feel most fulfilled when I’m in close communion with God.
    SA  MA  A  D  MD  SD

18. Life doesn’t have much meaning.
    SA  MA  A  D  MD  SD

19. My relation with God contributes to my sense of well-being.
    SA  MA  A  D  MD  SD

20. I believe there is some real purpose for my life.
    SA  MA  A  D  MD  SD

SWB Scale Copyright c 1982 by Craig W. Ellison and Raymond F. Paloutzian. All rights reserved. Not to be duplicated unless express written permission is granted by the authors or by Life Advance, Inc., 81 Front St., Nyack, NY 10960.
Appendix D

Invitation to Participate in the Study, Script for Potential Participants, and Email to Online Participants
Dear Church/Community Leader,

My name is Reuben Mwangi, a Kenyan student pursuing my doctoral studies in Counselor Education and Counseling Psychology at Western Michigan University. I am seeking your help in collecting information for a research study entitled “Attitudes Toward Professional Psychological Help Among Kenyan Immigrants Living in the United States,” designed to investigate attitudes toward use of professional counseling services. This study is intended to provide the counseling profession with information about mental health and spiritual well-being as it relates to Kenyan immigrants living in the United States. The study may be of value to practitioners and policy makers, and may provide a broad understanding of how Kenyan immigrants conceptualize mental health and professional intervention; thus better equip mental health professionals to be competent in working with immigrant populations. This research is being conducted as part of my dissertation requirements, and is comprised of demographic survey and two questionnaires that should take no more than 15-20 minutes to complete.

I would like your assistance by announcing this research study and its purpose in your church services, as well as distributing the survey and questionnaires to your church/organization members. In addition, I am asking you permission to personally give a brief explanation of the study on a given church service or meeting that is most convenient to you. This will give me an opportunity to introduce myself to the church as well as to encourage the congregation to participate in the study.

To participate in this study, individuals must be: (a) men or women, 18 years of age or older; and (b) must be Kenyans who: (1) immigrated to the United States (2) are currently residing within the United States.

Please contact me at your earliest convenience to let me know of your willingness to participate in this project. If you have any questions, you may contact my dissertation Chair, Dr. Mary L. Anderson at 269-387-5108 or me at 616 827-3305. You may also contact the Chair, Human Subjects Institutional Review Board (269-387-8293) or the Vice President for Research (269-387-8298) if questions arise during the course of the study.

Sincerely,

Reuben M. Mwangi, MA, LPC
Doctoral Candidate
Department of Counselor Education
and Counseling Psychology
Western Michigan University
Script for Potential Participants

Good morning/afternoon/evening, my name is Reuben Mwangi. I am a doctoral student in Counselor Education and Counseling Psychology at Western Michigan University. I am conducting a research project for my dissertation entitled, “Attitudes Toward Professional Psychological Help Among Kenyan Immigrants Living in the United States.” This purpose of this study is to provide the counseling profession with information about mental health and spiritual well being as it relates to Kenyan immigrants living in the United States.

The pastor or representative (Name) has given me permission to ask if you would be willing to participate in this research study. Your participation will consist of completing a survey/questionnaire consisting of three sections, the first section is a demographic questionnaire that will ask you to provide information about yourself, such as age, level of education, length of stay in US, acculturation, and whether you have been seen by a counselor etc. Section II will ask you to respond to questions related to your attitudes toward seeking psychological/counseling help from a professional; section III asks about your spiritual well being. The survey takes no more than 15-20 minutes to complete. Your participation in this study is strictly voluntary.

There is an anonymous consent form attached to the survey that explains your participation, risks and benefits. Detaching the anonymous consent form and keeping the form for your record is your agreement to participate in this study. Thank you and I will be glad to answer any questions you may have.

Reuben M. Mwangi, MA, LPC
Email to Online Participants

You are invited to participate in a research study entitled, “Attitudes Toward Professional Psychological Help Among Kenyan Immigrants Living in the United States.” In order to participate in this study, you will be required to satisfy the following criteria: (a) men or women must be 18 years of age or older; (b) must be Kenyans who: (1) immigrated to the United States (2) are currently residing within the United States.

This survey is comprised of demographic survey and research survey comprised of two questionnaires and should take no more than 15-20 minutes to complete. Your participation in this study is strictly voluntary. Information collected from you in this study will be anonymous.

Thanks in advance for your assistance. If you have any questions or concerns, please feel free to contact Reuben Mwangi by phone at (616) 827-3305 or via email at reuben.m.mwangi@wmich.edu. You can also contact my dissertation chair, Dr. Mary L. Anderson by phone at 269-387-5108 or by email at mary.l.anderson@wmich.edu.

To learn more about the study and to participate if you decide to, please click on the survey link: (Survey Monkey)

Sincerely,
Reuben Mwangi, MA, LPC
Doctoral Candidate
Counselor Education & Counseling Psychology
Western Michigan University
Appendix E

Informed Consent Document
You have been invited to participate in a research study titled “Attitudes Toward Professional Psychological Help Among Kenyan Immigrants Living in the United States,” designed to investigate attitudes toward utilization of professional counseling services. This research is being conducted as part of the dissertation requirements for Reuben M. Mwangi. This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participating in this research project. Please read this consent form carefully and completely and please ask any questions if you need more clarification.

This study is intended to provide the counseling profession with information about mental health and spiritual well being as it relates to Kenyan immigrants living in the United States. To participate in this study, you will be required to satisfy the following criteria: (a) men or women must be 18 years of age or older; (b) must be Kenyans who: (1) immigrated to the United States (2) are currently residing within the United States.

This survey is comprised of demographic survey and research survey comprised of two questionnaires and should take no more than 15-20 minutes to complete. Your participation in this study is strictly voluntary. If you chose not to participate in this study, there will be no associated penalties. Further, if you choose to participate, you may discontinue your participation at any time without any penalty. Your replies will be completely anonymous; so do not put your name anywhere on the form. There are no expected risks involved in participating in this study other than the limited loss of time spent to complete the survey. However, the findings from this research study will advance knowledge about this topic and may benefit human service and mental health professionals who may work with Kenyan immigrant population.

If you chose not to participate in this study, you may either return the blank survey or you may discard it. Returning the completed survey indicates your consent for use of the answers you supply. Should you have any questions prior to or during the study, you can contact the primary investigator, Dr. Mary L. Anderson at 269-387-5108 or me at 616 827-3305. You may also contact the Chair, Human Subjects Institutional Review Board (269-387-8293) or the Vice President for Research (269-387-8298) if questions arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this project if the stamped
date is older than one year. Please keep this page for your records. Detaching and keeping the consent form is an indication that you have consented to participate in this study.

I have read this informed consent document. The risks and benefits have been explained to me. I agree to take part in this study.

Please Print your Name

Participant’s signature  Date
Appendix F

Follow-up Invitation to Participate in Study
Dear Church/Community Leader,

Two weeks ago I sent you an email seeking your help in collecting information for a research project entitled “Attitudes Toward Professional Psychological Help Among Kenyan Immigrants Living in the United States,” designed to investigate attitudes toward use of professional counseling services. This research is being conducted as part of my dissertation requirements, and is comprised of demographic survey and two questionnaires that should take no more than 15-20 minutes to complete. I would like your assistance in distributing the survey and questionnaires to your church/organization members.

To participate in this study, individuals must be: (a) men or women, 18 years of age or older; and (b) must be Kenyans who: (1) immigrated to the United States (2) are currently residing within the United States.

Please contact me at your earliest convenience to let me know of your willingness to participate in this project. If you have any questions, you may contact my dissertation Chair, Dr. Mary L. Anderson at 269-387-5108 or me at 616 827-3305. You may also contact the Chair, Human Subjects Institutional Review Board (269-387-8293) or the Vice President for Research (269-387-8298) if questions arise during the course of the study.

Sincerely,

Reuben M. Mwangi, MA, LPC
Doctoral Student
Department of Counselor Education and Counseling Psychology
Western Michigan University
Appendix G

HSIRB Approval Document
Date: July 21, 2015

To: Mary Anderson, Principal Investigator
    Reuben Mwangi, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 15-04-30

This letter will serve as confirmation that the change to your research project titled “Attitudes toward Professional Psychological Help among Kenyan Immigrants Living in the United States” requested in your memo received July 20, 2015 [to revise “Consent for Online Data Collection Document” to comply with the “Spiritual Well-Being Scale (SWBS) copyright requirement] has been approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: May 18, 2016