DEPRESSION AND NIGERIAN-BORN IMMIGRANT WOMEN IN THE UNITED STATES: A PHENOMENOLOGICAL STUDY

A DISSERTATION

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BY

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To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Ifeoma E. Ezeobele entitled "Depression and Nigerian-born Immigrant Women in the United States: A Phenomenological Study." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Nursing Science.

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DEDICATION

This dissertation is dedicated to the loving memory of my late Dad, Pa Timothy Mazi Ezebuiro, who died in January 1994. He sacrificed everything he had to give his six children a university education. Pa, you were the first person in your village to send your children to Germany and England to study in the 1960s; in 1979, you sent me to the United States. I know you would be very proud of me for achieving this enormous milestone. Your fatherly advice is not forgotten. Whatever I do, and wherever I go, I always remember your quotes; they echo in my mind. You used to say that, "Man is an architect of his own person", and "Do not say my father is this, or, my father is that, what are you?" I remember your Bushman greeting for hello, "mutara." You were always present to meet the educational and financial needs of your children. You gave us the very best of everything you had. Thank you for giving us a wonderful and enriching upbringing. You have instilled in your children that education is the ultimate key to success in life, and this is evidenced by your children's successful endeavors, work ethics, and self-actualization in our community.

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Six long years have come and gone. During those six years, I have learned a lot about myself and the world around me. I have come to understand depression from the perspectives of Nigerian-born immigrant women in the United States (U.S.). Being a Nigerian-born woman, I have learned how to persevere and use my strong cultural upbringing to soar to this apogee.

I would like to first thank God for guiding me through this challenging endeavor and making it possible to achieve a goal that I set for myself almost 10 years ago.

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During the past six years, I went through tremendous challenges. I was stricken with cancer during my first semester in the doctoral program. Through God's guidance and protection, I was able to overcome it. I underwent extensive chemotherapy and radiation, but I did not falter because I had a goal in mind. My goal was to get the "golden fleece." I was so determined that even in my dark

days of cancer therapy, I took some of my doctoral courses on-line, remaining very strong willed, and refusing to be overshadowed by the illness.

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ABSTRACT

IFEOMA E. EZEOBELE

DEPRESSION AND NIGERIAN-BORN IMMIGRANT WOMEN IN THE UNITED STATES: A PHENOMENOLOGICAL STUDY

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This phenomenological study, using the Husserlian philosophy, explored the perceptions of Nigerian-born immigrant women in the United States and their portrayal of depression. Through face-to-face, semi-structured, audiotaped interviews incorporating open-ended questions and probes to facilitate discussion, the study examined a purposive sample of 19 Nigerian-born immigrant women's perception of depression. Data was analyzed using Colaizzi's seven step method of data analysis. The findings from the study uncovered six themes: (a) craziness and madness, (b) curse and evil spirit possession, (c) denial and secrecy, (d) isolation and rejection, (e) spirituality and religion, and (f) need for education. Findings indicated that Nigerian-born women were not able to differentiate depression from other types of mental illnesses. The women described depression as something that affects others and not them. The women's perception provided insight into why the clergy was preferred for treatment of depression rather than health care professionals. The findings of the study should increase the awareness of nurses and other health care

professionals of the need to focus on evidence-based, culturally specific research, and illuminate issues surrounding depression in this population.

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INTRODUCTION

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Depression is one of the most serious health problems experienced by immigrant women and studies have found more psychological distress in immigrant women than in immigrant men (Kim & Rew, 1994; Miller, Sorokin, Wilbur, & Chandler, 2004; Ritsner, Ponizovsky, Nechamki, & Modai, 2001). Depression is a common sequel of the process of migration, and its associated processes can produce considerable stress for those who are migrating, as well as for those around them (United States [U.S.] Surgeon General Report, 1999). Migration involves moving from a familiar culture to a foreign culture. According to Kasl and Berkman (1983), this move can be a major stressful life event that involves difficult life adjustments and persistent strain. The strain of migration affects the mental health of the immigrants, and women are likely to experience the strain differently, and more seriously, than men (Aorian & Norris, 2003, Kim & Rew, 1994; Munet-Vilaro, Folkman, & Gregorich, 1999).

Migrating to a new environment places the women in situations where they experience stress and anxiety due to the loss of traditional support systems and a familiar environment (Bhugra, 2003; Espiritu, 1997; Kamya, 1997). The

women may experience an increased incidence of depression as a result of their new minority status, as well as their changed social roles.

The U.S. Census Bureau (2000) reported in its profile of selected demographic and social characteristics that 57,945 women living in the U.S. were born in Nigeria. This evaluation provides meaningful data on Nigerian-born women who may be susceptible to migration-related stressors. Incompatibilities between the home culture and the host culture may appear, becoming evident in differences between family and societal values, interaction styles and social roles (Guarnaccia & Lopez, 1998). The migratory process may be less traumatic with adequate preparation and social support for the immigrants, as well as the acceptance of the immigrants by the new host (Bhugra, 2004b; Guarnaccia & Lopez, 1998).

The Immigration Act of 1965 opened the doors to women to migrate to the U.S. seeking improved economic and social opportunities. This Act helped reunite families and facilitated the admission of skilled workers to boost the U.S. economy. Owing to global technology, political and economic developments, current international migrants are of an unprecedented volume (Gonneke, Vollebergh & Vollebergh, 2008). These migrants are highly heterogeneous because they involve a large diversity of migrant women who seek upward social mobility in the new country, as well as refugees who avoid persecution in their country of origin (Bhugra, 2004a).

Prior to the terrorist attacks of September 11, 2001, the U.S. immigration policy was an important factor that supported migration (Abdullah, 1999; Arthur, 2000). Additionally, the Nigerian economic and political future has been an important factor for the recent large-scale migration to the U.S. Two U.S. policies contributing to immigration trends are the 1986 Immigration Reform and Control Act and the Diversity Visa Program that was introduced as part of the 1990 Immigration Act (Krikorian, 2005). While the 1986 Act made it easier for undocumented immigrants, including those from Africa, living in the U.S. to become permanent residents, the Diversity Visa Program was aimed at promoting immigration from underrepresented countries and regions of the world. This program allowed up to 50,000 qualified Africans to migrate each year to the U.S. through a lottery process (Vaughan, 1997; Zeleza, 1999). African women, including women from Nigeria, who have remained in the background of the traditional culture found themselves at the forefront of economic and educational opportunities in the U.S. Nigerian women migrated to the U.S. either as wives, students, daughters, and/or mothers of U.S. permanent residents (Takougang, 2002). According to Daff (2002), most of the African women, especially those from West Africa, have stopped waiting for their husbands to mail checks to them from the U.S. Instead, these women migrate to the U.S. to join their husbands and often defy tradition by seeking employment and earning their own income. Other African women migrate alone to the U.S. leaving their husbands and

children behind (Daff, 2002). However, the immigrant African women living in the U.S. are often expected to continue maintaining the traditional family structure both for the family who remain in Africa and as well as for the family living in the U.S. (Macharia, 2003; Takougang, 2002).

The immigrant women often engage in multiple paid positions to ensure their economic survival and fulfill their cultural expectations (Reynolds, 2007).The women accept multiple jobs to break the cycle of fruitless mobility they experienced while in their homeland (Raijman, Schammah-Gesser & Kemp, 2003). Immigrant women are often quick to take any employment opportunity they can get, and they take jobs that they would have never taken in their home country (Reynolds, 2007; Takougang, 2002). Although about 100,000 college-educated African women professionals live in the U.S. (Djamba, 1999; Takougang, 2002, 2003), many of them work in jobs that require less education and skill. In these low paying manual or service jobs, immigrant women seldom advance in their social and linguistic skills (Catanzarite, 2005; Kats, 1982; Raijman, Schammah-Gesser & Kemp, 2003; Watson & Andrews, 2002). Furthermore, employment creates a heavy burden on the women as they are also expected to be the main caretaker of the family and the household. Nolen-Hoeksema and Keita (2003) explained that employment may add to women's psychological distress and consistently create role overload. The immigrant women work full time and continue to shoulder full responsibility of home chores

and child rearing (Raijman, Schammah-Gesser & Kemp, 2003; Raijman & Semyonov, 1997; Simon, 2000). The role overload suggests that immigrant women who are employed have the primary responsibility for both housework and children in addition to their job's demands (Nolen-Hoeksema, 1990; Raijman & Semyonov, 1997; Raijman, Schammah-Gesser & Kemp, 2003). Combining outside employment responsibilities with those of their families', the women suffer greater levels of demands. Though employment has been considered a major indicator of power relations in the family (Kats, 1982), the frustrations and conflicts arising from these work and family demands may contribute to the immigrant women's higher rate of depression (Lennon & Rosenfield, 1992).

Another source of stress caused by the migration process is loss of family, friends, customs, and surroundings (James, 1997). The immigrant women adapt to a new cultural environment that often includes different morale values, standards, and new language (Berry, 1990). According to Bhugra and Ayorinde (2004), immigrant women may often experience a lack of linguistic and social skills, ethnic prejudice, social isolation, and low access to social mobility tracks in the U.S. culture; additionally, they are at risk for unemployment and poverty. Many immigrant women who came from educated, wealthy, and influential upper echelon families may find themselves in the lower tiers of the U.S. labor market or even unemployed (Gonneke, Vollebergh & Vollebergh, 2008). The immigrant women take marginal job positions in the host country, making them occupy a

weak position that is at the bottom of the existing social hierarchy (Garcia, Crnic, Lamberty, Wasik, Jenkins, Vasquez, et al., 1996). The immigrant women's integration in the host society is often hindered by discrimination and restrictive policies affecting the immigrant women (Gonneke, Vollebergh & Vollebergh, 2008).

Statement of Purpose

The influx of African immigrants, including Nigerians, to the U.S. during the last two decades has been extraordinary (Takougang, 2002, 2003). According to the Immigration and Naturalization Services (INS), the total number of all African immigrants in the U.S., has quadrupled from 109,733 in 1960s to 531,832 in 2000 (Takougang, 2002). The U.S. Census Bureau (2000) reported that the number of Nigerian immigrants living in the U.S. is 134,940 (approximately 25% of all Africans). Of these 134,940 Nigerian immigrants, the number of Nigerian-born women was reported as 57,945 (approximately 43% of all Nigerian immigrants).

Research related to the health and wellbeing of immigrant women has been increasing, but existing research on depression and immigrant women has generally not addressed specifically the issue of depression and the Nigerian-born immigrant women. There are literature reports on depression and Hispanic, Asian, Jewish, Korean, Vietnamese, Russian, and Chinese immigrant women. Some researchers have examined African-American women but failed to identify

Nigerian-born women in their study sample, and consequently failed to recognize the cultural differences that exist among African cultures (Kamya, 1997). None of the existing studies have focused on the life situations and experiences that might have important effects on the Nigerian immigrant women's mental health. The Nigerian women's traditional patterns of behavior and cultural values differ greatly from those of U.S.-born African-American women.

Nigerian-born immigrant women may be unfamiliar with Western culture and have difficulty adjusting to Western lifestyles, beliefs, religions, and language. In the Nigerian culture, the traditional women's role is to take care of the children, support the husband, and have responsibility for the home. However, in the U.S., the Nigerian women often add employment onto their other traditional roles. Additionally, even though many Nigerian-born women are well educated with college degrees, difficulties in communication, lack of personal skills, and unfamiliarity with the new environment often force them to take low paying menial jobs that are completely unrelated to their former training and education (Takougang, 2002; 2003). African women immigrants are often faced with a reality that Aman (2002, p.13) calls "innocence about race relations" as they struggle to make a life in the U.S. The women are unaware and unprepared to encounter some of the same stereotypes often associated with their African-American counterparts' native to the U.S. (Nesbitt, 2002). Uwah (2002) questioned why successful African immigrants, including Nigerians, who uphold

the American values of hard work and education, and have embraced assimilation into the mainstream culture are still not accepted like other immigrants from Europe, Cuba, or Asia. The proposed study is designed to add to the body of research on this often overlooked and frequently misunderstood population.

Rationale for the Study

A paucity of qualitative studies exploring the lived experiences of immigrant women and depression exists. A thorough literature search did not reveal any studies examining depression from the perspective of Nigerian-born women. Illuminating the issues surrounding depression in Nigerian-born women will help health care providers to provide culturally competent care to this population.

Nigerian-born immigrant women may not perceive depression as a significant problem because their innate culture does not encourage acceptance of the illness. There is a strong belief in the traditional Nigerian society that the causative factors of depression are supernatural forces that can be influenced through manipulation by one's enemy. This manipulation does not occur within the traditional Western system. This study will identify and address potential gaps in understanding the nature of depression among Nigerian-born immigrant women leading to increased understanding by health care professionals on how indigenous spiritual beliefs may drive health seeking behavior. The Nigerian

cultural beliefs about the causes of depression should not only be addressed, but the purpose of the beliefs should be understood within the cultural context.

Cultures vary in the ways their members ascertain the causes, nature, and treatment of depression. Depression in the Nigerian context has a narrower focus than in the Western culture. According to Jegede (2005), depression was described as a manifestation of mental disorder in Nigerian culture, while in the Western culture, depression involves minor stages of mental problems when compared to other types of mental illness like schizophrenia. The lack of literature on Nigerian-born immigrant women's perspectives regarding depression may limit health care professionals' ability to develop strategies for providing culturally competent care. Understanding the meaning of depression from the viewpoint of Nigerian women is a stepping stone to providing culturally competent care to this population. According to Yoho and Ezeobele (2002), to provide culturally competent care, health care professionals will need to understand the cultural norms and boundaries of the population being studied.

Assumptions

The following assumptions were applied to the study:

1. Nigerian-born women can best relate their perception of depression through their narratives.
2. All participants are honest in their responses.

3. Participants will respond to questions based on their perceptions of lived experience.
4. Perception becomes the description of the signs that one's senses provide in accordance with bodily stimuli.

Research Questions

The following research questions were explored in this study:

1. What does depression mean to Nigerian-born immigrant women?
2. How do Nigerian-born immigrant women perceive depression?
3. What methods are used by Nigerian-born immigrant women in the U.S. to treat depression?

Definitions

The terms used in this study are defined as follows:

1. Depression

   Conceptual definition:

   Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression

can lead to suicide, a tragic fatality associated with the loss of about 850,000 lives every year (World Health Organization, 2008).

Operational definition:

No formal definition provided for this study.

2. Nigerian-born

Conceptual definition:

A Nigerian-born woman is a person born in the country of Nigeria, a republic in West Africa, located on the Gulf of Guinea that gained independence from Britain in 1960, and is the most populous African country (WordNet, 2008).

Operational definition:

A self-report of being born in the country of Nigeria

3. Immigrant Woman in the USA

Conceptual Definition:

An immigrant is a foreign national who intends to establish a permanent residence in the United States (New York University, Office for International Students and Scholars, 2008).

Operational definition:

A woman who self- reports to be 18 years of age or older, to have been born in the country of Nigeria, and to have emigrated directly to the U.S., from Nigeria.

Theoretical Framework

Husserl's (1962, 1970) phenomenology of perception provides the philosophical underpinning for this study. One assumption of Husserl's philosophy is that experience as perceived by human consciousness has value. According to Lopez and Willis (2004), Husserl believed that subjective information should be important to scientists seeking to understand human motivation because human actions are influenced by what people perceive to be real. Husserl thought that a phenomenological approach is needed to bring out essential components of natural and cultural experiences that are specific to a group of people. A second component of Husserlian phenomenology is the belief that it is essential to shed all prior personal knowledge to enable the researcher to grasp the essential natural experiences of those being studied (Lopez & Willis, 2004).

In this study, the phenomenological researcher aims at exploring and seeking understanding of depression from the unique views of Nigerian-born women. The researcher will use Husserl's bracketing to set aside her previous knowledge of depression in Nigerian culture. The researcher is a Nigerian-born woman who has been living in the U.S. for over 29 years. Additionally, she has been a nurse in the U.S. since 1979 and has been employed in a traditional U.S. mental health care environment for over 19 years.

The use of bracketing allowed the researcher to grasp the essential viewpoint of those being studied. The phenomenon came into view without biases from the researcher's preconceptions. Creswell (1998) explained that bracketing peels away layers of interpretations to allow the phenomena to be seen as they are. The researcher's goal was to achieve transcendental subjectivity, described as a force in Husserlian concept whereby the inquiry was constantly assessed, biases and preconceptions were neutralized, and any influence on the object of study was prevented (Lopez & Willis 2004).

Limitations

Limitations of the study include the following:

1. The study sample was composed of well-educated women and was self-selected (Barry & Mizrahi, 2005). Nigerian-born immigrant women who participated in this study were well-educated and reside in Houston, Texas and surrounding suburbs. The study group may not be representative of other Nigerian-born immigrant women. A more representative sample of Nigerian-born immigrant women in other parts of the United States could yield different results. Sixty-five percent of the study participants were from the Ibo ethnic group with few representations from other ethnic groups
2. An American-born professional transcriber experienced difficulties in understanding the Nigerian-born immigrant women's accent on

the audio-taped interviews. The professional transcriptionist marked "inaudible" on many lines on the transcripts. Oliver, Serovich and Mason (2005) explained that transcription is a powerful act of representation and a pivotal aspect of qualitative inquiry, which can affect how data are conceptualized. Transcription can powerfully affect the way participants are understood, the information they share and the conclusions drawn (Oliver, Serovich & Mason 2005).

Strengths

The strengths of this study include the following:

1. Purposive sampling was used to select participants who are Nigerian-born women, raised in Nigeria, and migrated directly from Nigeria to the U.S. Purposive sampling allows the researcher to select information-rich participants whose study will illuminate the question under study (Patton, 2002).
2. The researcher is a Nigerian-born immigrant woman. Daunt (2003) discussed ethnicity and recruitment rates in clinical studies and explained that knowledge of potential subjects was essential in recruiting immigrant women to participate in a study. The researcher in this study is a Nigerian-born woman who understands Nigerian culture and has established trust in the community. These strategies minimized mistrust and made recruitment efforts

successful. The researcher collected all data from participants and data analysis was filtered through the researcher's perception.

3. The researcher reviewed the transcribed data and identified missing information. The researcher, who understands the Nigerian-born women's accents went back to the tapes, listened to each audio tape and captured all the missing data which were identified as "inaudible" by the U.S.-born professional transcriptionist on each transcript.

Summary

Depression is one of the most serious health problems experienced by immigrant women as a result of their minority status in a new environment and the loss of traditional support systems. The Nigerian-born women may be targets for gender discrimination because of their African ethnicity and female gender. A paucity of qualitative studies exists exploring the lived experiences of depression and immigrant women. Additionally, no study has examined depression from the perspective of the Nigerian-born women. Nigerian-born women immigrants are reported to be increasing in number. The U.S. Census Bureau (1998) reported that the number of Nigerian-born women living in the U.S. was 52,930 in 1990, and had increased to 57,945 in 2000 (U.S. Census Bureau, 2000). Nigerian-born women may not perceive depression as requiring health care because of strong

beliefs that the causative factors are supernatural and preternatural. Cultures vary in ways of ascertaining the cause, nature, and treatment of depression.

The lack of literature on the perspectives of Nigerian-born immigrant women about depression may limit health care professionals' ability to develop culturally competent care strategies for this population. Understanding depression from Nigerian-born women's viewpoint is a stepping stone to providing culturally competent care. The researcher, who is a Nigerian-born woman, employed a phenomenological design to explore the perceptions of depression from the unique view of the Nigerian-born immigrant women. Husserl's bracketing was used by the investigator to review previous knowledge and presumptions held about depression in the Nigerian culture. Bracketing allowed the researcher to grasp the essential viewpoint of those being studied and permitted the phenomenon to come into view without distortion by the researcher's pre-conception.

CHAPTER II

REVIEW OF LITERATURE

Depression is one of the most serious health problems experienced by immigrant women. Studies tend to find more psychological distress in immigrant women than in immigrant men (Ritsner, Ponizovsky, Nechamki, & Modai, 2001). Age consistently correlates with psychological symptoms in immigrants, and people who migrate during and after midlife years tend to have higher levels of depression than those in the general population (Miller, Sorokin, Wilbur, & Chandler, 2004). Depression is a common sequel of the process of migration and its associated processes can produce considerable stress on those who are migrating as well as on those around them (United States Department of Health and Human Services [USDHHS], 1999).

The initial focus of this literature review was to identify publications related to depression in Nigerian-born immigrant women. The nursing literature was searched via the Cumulative Index of Nursing and Allied Health literature (CINAHL). Other data bases, including Web of Science, Medline, Psych Info, ERIC, Cochrane Library, Dissertation, Ovid, PUBMED, and Wilson Social abstracts were explored from the 1960s to the present. The search included keyword terms depression, immigrants, women, cultural beliefs, etiology of depression, and Nigerian women. The search was limited to human subjects and

publications in the English language. When the search was conducted using the key words "depression" and "Nigerian immigrant women," the results found no literature on this population. Search strategies were revised and expanded to "depression" and "immigrant women." The results revealed a plethora of studies on many immigrant women populations but not a single report on Nigerian immigrant women. These articles were reviewed in order to gain information on depression in immigrant women. One review of literature on immigrant women (Kamya, 1997) reported that between 1990 and1995 most studies have focused only on Hispanic, Asian, Jewish, Korean, Vietnamese, and Russian immigrant women. Studies have been conducted with African-American women, but did not specifically identify Nigerian-born women or women from other African countries in the study samples, thus failing to recognize the cultural differences that exist among African cultures (Kamya, 1997).

Therefore, this literature review will present an overview on findings related to depression and immigrant women. Previous studies have indicated that immigrant women's mental health has been associated with issues of the process of immigration, cultural beliefs and attitudes, and family relationships.

The Immigration Process

The African-American population in the U.S. has become more heterogeneous through migration. According to Miranda, Siddique, Belin, and Kohn-Wood (2005), from 1970 to 2000, the overall foreign-born black population

increased nationwide from 1.3% to 7.8% and most of the black immigrants came from Africa. The mental health of these immigrants has been the subject of debate since the end of the nineteenth century (Vander & Link, 1998). Nigerian immigrants are the fastest growing segment of the immigrant population in the U.S. (Sellers, Ward, & Pate, 2006). However, despite the large number of Nigerian immigrants in the U.S., statistics related to depression in Nigerian-born women are either non-existent or very minimal. The Nigerian-born women represent a specific vulnerable population (Kamya, 1997). Part of the perplexity is due to scarcity of published clinical research on depression in African women, including Nigerian women (Barbee, 1992). This scarcity, in part, is due to the fact that Nigerian-born immigrant women may not seek treatment because of their innate culture, moreover, their ethnic, cultural, and/or gender needs may not have been met (Warren, 1994). Another reason for scarcity in research is Nigerian-born women may be reticent to participate in research studies because of fear that the research data will be misinterpreted (Warren, 1994).

Bhugra and Jones (2001) reported that when individuals migrate from one culture to another, the cultural and ethnic identity is likely to change. The Nigerian-born immigrant women migrate from Nigeria, a socio-centric culture, to the U.S., an egocentric society. According to Wang (2002), socio-centric cultures stress the necessity of striving for collectivity. Individuals in the socio-centric culture sacrifice their hopes and desires in the name of collective interest.

Conversely, egocentric society stresses individuality. Egocentric society often leads to separations, divisions, strife, and polarizations in all aspects of human life. Egocentric society treats the individual as an isolated, competitive entity, an autonomous agent with minimal relationship or obligation to other people (Wang, 2002). The Nigerian-born immigrant women may find it difficult to adjust in the egocentric culture because the host society may expect them to behave according to the egocentric culture, while Nigerian society expects the women to stay firmly within their socio-centric culture (Bhugra and Jones, 2001; Warnock, 2006). As a result of these expectations, the Nigerian-born immigrant women may likely experience cultural confusion and culture shock (Bhugra & Jones, 2001).

Miranda, Siddique, Der-Martrosian, and Belin (2005) study found that increasingly, women are emigrating to the U.S. from Latin America and leaving their children in their homeland in the care of family or friends. Data from their study indicate that mothers who leave their children as they immigrate to the U.S. reported higher rates of depression than immigrant women who did not experience such separations.

Studies have found that immigrant women who migrate are more likely to be at risk of developing mental disorders (Bhugra, 2004a; Kamya, 1997; Ritsner, Ponizovsky, Nechamki, & Modai, 2001). A major factor that causes depression is communication. Fluency in the language of the new society can influence how

well the women communicate in the new society (Bhugra, 2005). Significantly, regardless of the circumstances that led to migration, individuals migrating do not leave their cultural beliefs behind (Bhugra, 2005). These beliefs influence the extent of their expression of symptoms as well as their help-seeking behaviors (Das, Olfson, McCurtis & Weissman, 2006). Bhugra (2005) explained that persistent problems in cultural adaptation are associated with a higher risk for long-term mental health problems. The period of adaptation will depend on the individual's personality, reasons for migration, and the new society's acceptance of the immigrant. The effects of post-migration factors related to loss of social roles, confidants, and the acceptance of the immigrants by the host society play an important role in the process of adaptation (Takougang, 2002).

The migratory process can be manageable and less traumatic with adequate preparation and social support, as well as acceptance by the new culture. Factors that play an essential role in adjustment to migration include how the new country welcomes Nigerian-born immigrant women, their legal status which may be either voluntary or involuntary, and economic factors (Bhugra & Ayorinde, 2004). According to Barbee (1992), African women including Nigerian-born women may experience increased incidence of depression as a result of their minority status, their socioeconomic status, and their multiple social roles. Some researchers have reported the immigrant women continuously experience multiple risks and oppressions (Guitierrez, 1990; Morris, 1993).

Bochner (1986) in his study suggested that two modes of cultural contact govern the reaction of people to unfamiliar cultures: (a) adjustment to the new culture and (b) reflective learning of the new culture. Often individuals exposed to another culture may reject their culture of origin, reject the new culture, militantly retreat into their own culture, and/or vacillate between the two cultures. Bhugra and Ayorinde (2004) identified three stages of migration (pre-migration, the migration itself, and post-migration) which are not discrete. The pre- and post-migration stages last for varying periods depending on the individual. The rates of depression are related to length of stay of the immigrants in the U.S. The period immediately after migration is likely to be a vulnerable time to develop depression, and the period five to seven years later when the women have settled down but have not fulfilled their aspirations (Bhugra, 2003).

Furnham and Bochner (1986) highlighted eight theoretical constructs for adjustment following the process of migration that may result in depression for the immigrant women. The constructs include loss, fatalism, selective migration, expectations, negative life events, social support, social skills deficit, and a clash of values with the new culture. Theoretically, immigrant women who have lost a number of support factors may be more prone to depression, but according to Bhugra and Ayorinde (2004), not all immigrant women develop depression. However, personal vulnerabilities and the experiences of the immigration process

including culture shock and cultural identity loss may also contribute to depression.

Immigrant women may emphasize different symptoms. Additionally, the symptoms the Nigerian immigrant women may present are culturally driven (Jegede, 2005). Depression in ethnic minority populations across the world varies and these differences may be due to culture-specific patho-protective and pathogenic factors (Ahmed & Bhugra, 2006). Innate culture shapes the perception and expression of distress and could lead to disproportionate denial of psychiatric symptoms in the immigrant women. In a study conducted by Miranda, Siddique, Belin and Kohn-Wood (2005), one explanation for lower rates of depression among immigrant samples as compared with the U.S.-born samples is the diagnostic categories that are driven largely by Western psychiatry. The immigrants may not fit into the Western diagnostic criteria. Somatic symptoms may serve as a similar expression of distress in different cultural groups. Gilbert and Allen (1998) explained that cognitive factors may contribute to social withdrawal, which results in a sense of despair and alienation.

According to Kamya (1997), immigration involves the process of acculturation. At the cultural level this involves adjusting to the new culture and environment, at the personal level, the immigrant women must sort out interpersonal relationships, while at the intra-psychic level, the women must learn

to cope cognitively, attitudinally, and behaviorally in the new cultural system (Kamya, 1997).

Integration to U.S. Culture

Over the past decade, nearly 71,285 Nigerians have relocated to the U.S. (Migration Information Source, 2004; U.S. Census Bureau, 2000). As the women integrate into the host egocentric culture, they may find it difficult to adjust and consequently may develop psychological and psychosocial problems that manifest as physical symptoms. The women juggle between the host culture and their own culture. The host culture may expect them to behave in a certain way, while the women's culture may expect them to remain firmly in their original culture, thus resulting in a clash of cultures (Bhugra, 2003).

Social relationships in the U.S. are based on the dominant value of individualism, in contrast to the immigrant women's values of collectivism and group cohesion (Yi & Jezeweski, 2000). The Nigerian-born women, migrated from a socio-centric society, are seen as a visible minority within the egocentric society. The egocentric society describes itself as multicultural, but continues to hold ego-centric ideas and concepts. Schreiber, Stern, and Wilson (1998) described egocentricism as a mechanism that makes those from non-dominant societies feel excluded in the mainstream. The Nigerian women may find it difficult to adjust in the new environment. Since these are women of color, they

are likely to experience a range of discrimination in their daily lives that is both subtle and includes differential treatment at work and school.

Ahmed and Bhugra (2006) suggested that the women may express their depressive illness as culturally patterned idioms of linguistic and bodily styles, cultural ways of talking about depression. The women may exhibit symptoms that are culturally-driven as their culture shapes perception and expression of distress. Ahmed and Bhugra (2006) recommended strategies that will help raise awareness of symptoms in this population. Such strategies will provide tools and models that can help in the diagnosis and treatment of depression in this culture. In his study, Ebigbo (1982, pp. 29-32) described idioms used in Nigerian culture to describe depression like "heat in the head," "biting sensation all over the body," and "heaviness sensation in the head." These symptoms may manifest after the initial resettlement tasks have been accomplished, and only at this time are the women aware of the depth of their losses, which may result in grief and sadness (Ahmed & Bhugra, 2006). The women are also faced with adjusting to the demands of the new and foreign environment (Ahmed & Bhugra, 2006).

According to Kuo (1976, p. 297), social isolation experiences contribute to "strong feelings of loneliness, alienation, de-socialization, low self-esteem and inability to cultivate or sustain social relationships." Grief or bereavement may serve as blocks to coping with or adjusting to the demands of the new environment. Limited contact and communication with the larger society due to

social isolation is associated with greater stress in the immigrant women's performance of their social roles. For the immigrant women, changes in roles and or role expectations are frequently cited as stressors that might directly or indirectly contribute to the onset of mental illness (Kuo, 1976; Taft, 1977).

Studies of immigrant groups have shown that social isolation may be moderated by membership in associations that provide social support for new immigrants (Kuo, 1995). According to Arthur (2000), African immigrants are able to support one another through immigrant organizations. Many Nigerian-born immigrants tend to settle near fellow Nigerians. While this caucusing gives many Africans strength to work together and enable the continuation of ethnic or national cultures, it also alienates many Africans from the host culture with which the women must constantly negotiate for their survival. Living in settlements near other Nigerians heightens their visibility in the community, and decreases their vulnerability to the discrimination and oppression that confront them as they seek to enter the mainstream culture. Often the immigrant women rely on informal services and seek solutions to their problems from among their own people in their place of settlement (Arthur, 2000; Kuo, 1995).

Acculturation Issues

The Nigerian immigrant women face many challenges as they contact the new host society. These challenges may be in the form of adjusting to a new language, the different customs and norms for social interactions, the unfamiliar

rules and laws, and in some cases, the extreme lifestyle changes (Organista, Organista & Kurasaki, 2002). According to Berry and Kim (1988), the demands of adapting to these types of cultural differences can lead to increased acculturation stress. Accumulating evidence has suggested that acculturation stress may have important implications for mental health. A number of researchers have found that acculturation stress increases the risk for developing psychological problems, particularly in the initial months of contact with the new host society (Yeung & Schwartz, 1986; Zheng & Berry, 1991).

In a study of Southeast Asian immigrants in the northeastern U.S., persistent acculturation stress is the strongest predictor of poor mental health status of those immigrants who were more than four years post-migration (Nicholson, 1997). Difficulties learning the new language and problems seeking employment are typical acculturation stressors that are associated with depression. Westermeyer and Her (1996) conducted a study of Hmong immigrants in Minnesota at 1.5 and 3.5 years after their arrival in the U.S. Using English language proficiency as an indicator of acculturation, they found a significant negative relationship between acculturation and psychological functioning.

A Salgado de Snyder (1987) study of Mexican immigrants used a telephone survey for data collection. The questionnaire measured circumstances of the immigration experience, loyalty towards Mexican culture, self-esteem,

depressive symptomatology, general satisfaction, and demographic information. Depressive symtomatology was measured with the Spanish version of the Center for Epidemiology Studies Depression Scale (CES-D). Acculturation stress was conceptualized as a set of potentially stressful situations that an immigrant faces in an unfamiliar culture and environment (Salgado de Snyder, 1987). Findings to the study indicated a very strong and significant correlation between acculturation stress and depressive symptomatology.

Language problems, including accents, are the number one biggest challenges Nigerian born immigrants face in the U.S. Communicating with different accents can impede their access to health care, employment, and education. Pounce, Hays and Cunningham (2005) reported that the degree of English proficiency has been shown to be a dominant component of acculturation into the U.S. society. Limited English proficiency in the U.S. may affect functioning in other important domains like employment (Organista, Organista & Kurasaki, 2002).

The post-migratory stressors hinder opportunity to regain their prior level of psychosocial and economic self-sufficiency. Kurtz, Malcolm, and Cournoyer (2005) stated that stressors included learning the new language, adjusting to new roles, learning new skills, and entering mainstream vocational and educational programs. The achievement and expectation stressors are integral parts of the experiences of the Nigerian-born immigrant women. When achievement does not

match aspirations, the women will be faced with low mood, a sense of alienation, and a sense of failure (Bhugra & Ayorinde, 2004). Achievements and expectations can produce stress. Expectations from U.S. society in relation to personal and social gains must be matched with the achievement of the immigrant. When achievements do not match aspirations, the women may experience low mood, a sense of alienation, and a sense of failure, which is likely to trigger depression (Bhugra & Ayorinde, 2004). In a study conducted by Miller and Chandler (2002) to examine depression from 200 women from the former Soviet Union, age 45 to 65, who had lived in the U.S. fewer than six years. Data for analysis was from a cross-sectional study that explored the impact of immigration during midlife on women's health. Findings indicated very high scores on the depression scale compared to U.S. norms. Older women, and those reporting greater demands of immigration, had higher scores on the depression scale. Lower scores were found for women reporting greater English usage.

Many Nigerian-born women experience stress as they strive toward achieving their goals. Goal-striving stress points to the women's problem of unfulfilled aspirations. Newly arrived immigrants hold "a reasonable level of aspiration while they strive hard for achievement" (Kuo, 1976, p. 298). The women may experience difficulty in achieving upward mobility. These difficulties produce goal-striving stress which results in failure to achieve or maintain one's

own or host society standards. The women are often involved in multiple roles as they attempt to survive economically and advance themselves and their families through mainstream society. These factors intensify the amount of stress within the women's lives which may erode their self-esteem, social support system, and health (Warren, 1997).

Nigerian-born immigrant women are often consumed by the need to succeed. They will take on jobs and work long hours, even in the face of medical or mental crises, simply because the urge to succeed overrides other concerns. The women will often take subservient positions at the expense of their mental health (Takougang, 2003).

Taylor and Turner (2002) reported that African women have a jeopardy status which places them at risk for developing depression. These women live in a majority-dominated society that frequently devaluates their ethnicity (Warren, 1997) and the women often find themselves at the lowest spectrum in the U.S. political and economic continuum (Takougang, 2003).

Racism and Discrimination

Kim and Berry (1986) explained that those whose appearance makes them distinct from the dominant population may be less attracted by assimilation or be kept from assimilation by racism and discrimination. The Nigerian women's physical and cultural attributes often make them vulnerable. Bell and Doucet (2003) explained that discrimination contributes to economic inequalities that

these women must endure, which have direct and demonstrable effects on the women's mental health. The onset of depression in the immigrant women has been linked to humiliating experiences and severe life events that are common in women who are experiencing hardship in the new host environment (Bell & Doucet, 2003).

Schreiber, Stern and Wilson (1998) suggest that most immigrant women acknowledged racism as part of their existence but try to rise above it. In a qualitative study with twelve black West Indies women, the researchers sought to understand how these women managed their depression and moved toward recovery. The women identified that racism is a reality in their lives and a major factor to their depression, but felt they could rise above it rather than face it. The women indicated their upbringing had a lot to do with how they handle racism. The women dealt with racist remarks by relying on their own knowledge, understanding, and by dismissing such remarks as ignorant. The women handled racism by "turning the other cheek" (Schreiber, Stern & Wilson, 1998, p.113), and admitted that ignoring racism allowed them to manage their life within the racist context without becoming involved in the continuing, ongoing, and frontal assault against it. The women felt that engaging in a confrontational approach would require the use of personal resources and energy they may not have (Schreiber, Stern, and Wilson 1998).

The Noh and Kasper (2003) study examined how racism/ethnic discrimination may be related to depression. The authors focused on the ways in which individuals respond to perceived discrimination and how personal coping responses, as well as acculturation and ethnic social support, moderated the impact of perceived racial stigma on depressive symptoms. Health consequences of depression vary according to personal coping responses (Noh & Kasper, 2003). A study conducted in Toronto, Canada and cross-sectional data from personal interviews with Korean immigrants were analyzed. One hundred and eighty parents completed assessment, and the Korean version of the Center for Epidemiologic studies was used to measure depressive symptoms. In-depth open-ended questions were used to gather data on perceived discrimination and emotion/coping responses. Findings indicated that perceived discrimination and emotional reactions exhibited significant direct associations with depression as measured with the CES-D-K.

A qualitative study with African-born women was conducted in Canada in 1997 and 1998 by Wong (2000). The study used in-depth, semi-structured interviews to examine the labor market experiences of sixteen Ghanaian women living in Toronto, Canada. The result of the study corroborated previous studies on immigrant women's experiences of discrimination in the labor market. Wong (2000) discovered that most Ghanaian women interviewed had experienced some level of discrimination in their labor market experiences on basis of race,

ethnicity, gender, and immigration status. Most of the women in the study uttered statements such as "the most difficult thing about being in Canada is..... being an African you know...it's something you have to deal with everyday" (Wong, 2000 p. 10). Other women spoke of the subtle forms of racial and gender discrimination they experienced at work, which usually come in the form of dismissal from work without reason in favor of workers who were not of African origin (Wong, 2000).

The pain and the anger of racism encourage these women to take refuge in their own culture, to stick together and to suppress disharmony, no matter what form it might take (Wong, 2000). In this context, sustaining their native culture and identity was manifest in maintaining their beliefs and practices, improving relationships within the Nigerian family in the U.S. and maintaining their culturally acceptable values and roles.

Cultural Beliefs and Attitudes

The attitudes of Nigerians provide some background to understanding their depressive experiences. A strong cultural belief exists in Nigerian society that associates the causative factors of depression to supernatural or preternatural forces. Belief that these forces are the causes of depression shapes the women's worldview, which the women exhibit in their day-to-day interpersonal interactions with others. Warren (2000) contends that persons from diverse racial and ethnic groups' exhibit different world views to exist and

function within their racial/ethnic group. Warren suggests that world views blend when persons from different racial and ethnic groups interact and live with each other. Bhugra (2003) and Kamya (1997) suggested that when individuals migrate from their country to another, they do not leave their cultural beliefs behind, irrespective of the circumstances of their immigration. Cultural beliefs affect how the women define, evaluate, seek help, and present their symptoms (Bhugra & Jones, 2001).

Adewuya and Makanjuola (2005) conducted a study among university students in Nigeria to examine the level of social distance of students towards people with mental illness and to assess the possible socio-demographic involved. A modified version of Bogardus Social Distance Scale was administered to assess the desire for social distance towards people with mental illness amongst 1,668 students of a Nigerian federal university. A finding to this study indicated that social distance towards mentally ill is higher amongst Nigerian university students.

Jegede (2005) conducted a qualitative study in Ibadan, Nigeria on the differential conception and interpretation of mental illness by the Yoruba ethnic group, the second most populous ethnic group in Nigeria. The purposive sample was made up of three women and seven men, who were further categorized as traditional healers (five) and diviners (five). Participants were interviewed in different locations in Ibadan. The study, which lasted three months, used in-depth

interview questions to obtain data from the key informants. An emic view was used to interpret data received, and daily interpretation of data was done at the time of interview. The findings in this study indicate the participants' defined mental illness as a pathological problem of social relations where the individual looses a sense of reasoning and control (Jegede, 2005). The author explained the Yoruba ethnic group believed that mental illness can result from four perspectives.

The first perspective, natural source, is mental illness resulting from accidents or drugs. This type of mental illness is more acceptable in Nigerian culture and treatment is by herbalists who administer herbal treatments that are accompanied by all sorts of physical punishments and incantation to control the mind and thoughts of the patient. Patients are said to respond positively to this type of treatment. The patient gained access to his/her consciousness and the treatment brings the individual back to his or her normal self (Jegede, 2005).

The second, supernatural or mystical source results from the anger of the gods. To treat this type of mental illness, diviners are used and the diviner will confirm the type of spiritual therapy to apply. The diviners in Jegede's (2005) study explained that once the appropriate rituals and sacrifices are performed, the patient would maintain stable mental health. However, the problem can relapse if the individual violates the taboos of the gods again. The author used Biblical scripture to illustrate the relationship between sin and illness in which

Jesus Christ commanded, "go and sin no more so that more dangerous illness does not come upon you" (Jegede, 2005, p. 123).

The third perspective is the preternatural source which is usually caused by witchcraft. This type of mental illness, like the supernatural/mystical, is handled by the diviners. The diviner sees beyond the physical and explores the spiritual (Jegede, 2005). The fourth perspective, the hereditary source, is mental illness that is transferred from the family gene. This type of mental illness is believed by the Yorubas to have no cure (Jegede, 2005).

The Yoruba ethnic group in Nigeria does not believe that mental illness can be permanently cured. Mental illness is seen as a continuous process because a mentally ill person is being controlled by spirits which are ether due to a natural factor or other factors. Participants in Jegede (2005) study indicated that mentally ill person must be under permanent observation to prevent deterioration of illness. Among the Yorubas, mental illness has social significance for interpersonal relationships. Mental health forms part of the regulatory aspects of life, determine one's acceptance in the society, and have been associated with social instability in the community and marriage (Jegede, 2005).

Abiodun (1991) conducted a study that used a structured questionnaire to assess 207 primary health care (PHC) workers on the concept, attitude to, detection, and treatment of mental disorders. PHC workers without previous exposure to mental health training were significantly more likely to hold on to

traditional views on the etiology of mental disorders. Seventy-two percent of the PHC workers expressed a generally negative attitude towards mentally ill patients. Suggestions are made on the short- and long- term training requirements of the PHC workers in order to ensure the successful integration of mental health care into the primary health care program in Nigeria.

Adewuya and Makanjuola (2008) conducted a cross-sectional study in which respondents (n=2078) were administered a questionnaire detailing socio-demographic variables and perceived causation of mental illness in south-western Nigeria. The findings of this study indicated that beliefs in supernatural factors were the most prevalent. Educational status had no effect on the belief in supernatural causes.

Adebowale and Ogunlesi (1999) surveyed 70 insightful, clinically stable, out-patients with functional psychotic disorders and 70 accompanying relatives. The participants were interviewed about their beliefs concerning the cause of the illness, and their awareness of possible etiological factors. The results indicated that for both patients and relatives, the most common etiological suggestion was the "supernatural," while psychosocial stress was the least causative factor.

Sellers, Ward, and Pate (2006) conducted a qualitative study of well-being among Black African immigrant women in the U.S. Participants were recruited from two major African Associations. A letter was mailed to 50 households informing them of the study and inviting the families to participate. Leaders in the

African immigrant community were informed of the study to help foster trust and researcher credibility among participants.

Thirteen families were recruited through two major African associations in the U.S. Each participant received a cash gift of $20. Focus groups were facilitated by two doctoral students, one master's level student, and two undergraduate students. These students received training in group facilitation and research procedures. A brief demographic questionnaire was used to obtain background information. Data analysis in their study was guided by Kools, McCarthy, Durham, and Robrecht (1996) and Schatzman (1991). The key process in the analysis was to construct and understand the components of a complex multi-dimensional social phenomenon from the participants' perspective (Kools et al., 1996). Comparative analysis identified shared dimensions across participants and the various components of multi-dimensional social phenomena.

The participants in Sellers, Ward and Pate (2006) study described depression as madness. The words participants used to describe symptoms of depression appeared to be more psychosomatic in nature, like body aches, physical tiredness, and headaches. The contextual factors of depression, as suggested by participants, were associated with seven factors: change, parenting responsibilities, gender role strain, difficulties with systems, financial concerns, racism, and social isolation. The participants used culture-bound coping such as silence to cope with depression (Sellers et al., 2006).The participants also

described psychosomatic symptoms of depression, for example body aches, physical tiredness and headaches. The results of the study indicated that African, including Nigerian, immigrant women residing in the U.S. were concerned about depression and it was a major health and well-being concern.

Nigerian-born immigrant women's belief system provides some background for understanding depression. Gureje, Olley, Ephraim-Oluwanuga, and Kola (2005) conducted a study about causation knowledge of mental illness in Nigeria. A study was conducted between March and August 2002 in three Yoruba-speaking states, which are located in southwestern Nigeria namely, Ogun, Osun, and Oyo. The researchers used clustered probability sampling with stratified multistage household residents who were age 18 years and older to participate in the study. Trained interviewers from the University of Ibadan, Nigeria, Department of Psychiatry administered the surveys in the form of questionnaires to a total of 2,040 participants with a response rate of 74.2%. The questionnaires inquired of participants views about the causes of mental illness. The result of this study identified two groups of respondents: (a) those with exclusively bio-psychosocial views of causation of mental illness and (b) those with exclusive religious-magical views of causation as a result of possession by evil spirits or God's punishment. Findings suggested that knowledge of mental illness was generally poor in this ethnic group. Participants with psychosocial standpoint of causation of mental illness were more likely to believe in the

possibility of successful treatment outside the hospital. The bio-psychosocial group was slightly less willing than the religious-magical group to consider marrying a person with mental illness.

Quinn (2007) conducted a qualitative study to explore the impact of different cultural beliefs on society's response to mental illness, and to compare responses to mental illness in Ghana, West Africa. Semi-structured in-depth interviews were administered to 80 family caregivers across four sites in Ghana to explore themes, beliefs, attitudes, and support. Findings show a greater reliance on culturally specific explanations of mental illness, especially at the sites with strong traditional beliefs systems. There was a lack of understanding of presenting symptoms and their origin, which Quinn (2007) attributed to difficulty speaking openly about mental illness due to social implications. Most of the participants believed that mental illness resulted from natural causes. A small proportion believed that spiritual factors were responsible for onset of mental illness. The participants identified that an enemy can place a curse on an individual, causing mental illness. Persons with mental illness experienced both negative and positive attitudes from their families and communities. Data from the interview revealed that 12 of 20 relatives described positive attitude from extended family to persons with mental illness, while eight described the family ignoring the person with mental problems. Half of the participants in the study experienced acceptance of mental illness by their local community, while the

other half experienced lack of acceptance from their community. Quinn's (2007) study suggests the need for mental health education for the participants. The church or mosque was identified as an important source of support. Prayers had a role in the treatment of depression. Religious leaders provided emotional support and spiritual guidance.

Kibir, Iliyasu, Abubakar and Aliju (2004) examined the knowledge, attitude, and beliefs about mental illness among adults in a rural community in northern Nigeria. A cross sectional study design was used, and a pre-test semi-structured questionnaire was administered to 250 adults residing in Karfi village, northern Nigeria. Findings of the study show the most common symptoms reported by participants, as manifestation of mental illness, included aggression and destructiveness. Participants identified illegal drugs as major causes of mental illness, followed by divine wrath/God will (19%) and magic/spirit possession (18%). Literate participants were seven times more likely to accept a mentally ill person when compared to non-literate participants. The author identifies the need for community educational programs in Nigeria that are aimed at demystifying mental illness (Kibir et al., 2004).

Makanjuola, Adelekan, and Morakinyo (2000) conducted a study on current status of traditional mental health practice in Ilorin, Nigeria. Forty-three persons made up of 27 traditional mental health practitioners (TMHPs) and 16 patients' relatives (PR), participated in the study. Data was collected using

Practitioners' Questionnaire (PQ), Patient s' Relative Questionnaire (PRQ), and focus discussions and observations of TMHPs in their clinics. Factors which affect utilization of traditional mental health services were also reviewed. The findings indicated that TMHPs still enjoy considerable patronage from the populace, are more in numerical strength, and are more widely and evenly dispersed in the community than the orthodox mental health practitioners. About 74% of the TMHPs expressed interest in attending seminars aimed at improving their skills. Most of the patients' relatives expressed the belief that only traditional healers can understand the supernatural etiological basis of mental disorders, and can therefore offer more effective care than orthodox mental health practitioners (Makanjuola, Adelekan, & Morakinyo, 2000).

The Cultural Stigma

There is widespread stigmatization of mental illness within the bounds of Nigerian culture. Negative attitudes to mental illness are likely to be stimulated by the ideas of causation that associate mental illness to evil spirits. Several assumptions have been made about stigmatizing people with mental illness. It was widely believed that those who have more knowledge of mental illness, like medical doctors and mental health professionals, are less likely to allow negative or stigmatizing attitudes (Aydin, Yigit, Inandi & Kirpinar, 2003).

Adewuyi and Oguntade (2007) conducted a study to evaluate the attitudes of medical doctors in Nigeria towards the mentally ill. Using random sampling

techniques, 312 medical doctors from 8 selected health institutions in Nigeria participated in the study. The doctors completed various questionnaires on knowledge and attitude towards people with mental illness. Data was analyzed using univariate analysis. The results indicate that beliefs in supernatural causes of mental illness were prevalent. Mentally ill persons were perceived by participants as dangerous and their prognosis poor. Social distance was found to increase towards mentally ill persons when intimacy is required in the relationship. Findings from Adewuyi and Oguntade (2007) study indicated that 80.89% of participants would not marry someone with a mental illness. Additionally, 77.9% of participants would not accept a fully recovered former mental patient as a teacher of young children in a public school, and 92.0% would not hire a former mental health patient to take care of their children. The majority of the participants believed that misuse of drugs and alcohol was the major cause of mental illness, followed in succession by evil spirit/witches/sorcery (58.8%), and stress (58.3%). Previous community-based studies in Nigeria had identified that the most endorsed causes of mental illness by lay people were misuse of drugs, possession of evil spirits, and stress. The findings in this study show that this belief was not only limited to the public, but also popular among medical doctors. Culturally enshrined beliefs about mental illness were found to be prevalent among Nigerian medical doctors (Adewuya & Oguntade (2007).

The few mental health studies that have been conducted among African women in diaspora on mental illness showed that conceptualizations stem from people's own observations, understanding and interpretation of specific symptoms, the behavior of affected persons, and, how these symptoms are experienced and explained in a specific culture (Babee, 1992; Bulus, 1996; Madu, 1996). The African culture exhibits cultural reluctance in endorsing depressive symptoms (Weissman, Bland, Canino, Faravelli, & Greenwald, 1998).

The Akighir (1982) study investigated traditional psychiatry and modern psychiatry in Plateau state, Nigeria. Participants completed a survey on their perceptions and beliefs. A purposive sample that comprised 80 Nigerians with varied educational level and locality (rural and urban) was used. The results of his study suggested that attitudes toward traditional healers are generally favorable, mystical causes of madness are the most popular, and traditional healers are felt to have an important role to play in treating mad people. These conclusions applied regardless of the participant's educational level.

Schreiber, Stern and Wilson (1998) conducted a qualitative study with a sample of Black West Indian women in Ontario, Canada. A snowballing technique was used to recruit 12 participants. The women identified themselves as having experienced or recovered from depression. Interviews were taped and transcribed at a later time. Each participant was interviewed one to four times. The average age of participants was 39. Nine of the women were born in West

Indies, while two were born outside of the West Indies of West Indian parents. All but one of the participants had post-secondary education, and four had baccalaureate degrees. Results of the study suggest that West Indian women in Canada were reluctant to seek professional help for depression. The participants reported that any woman who is identified to be depressed would immediately suffer social isolation and social sanctions and the primary consequence was shunning. The women in the study strongly felt they would be labeled with comments like "look there, she's crazy" or "be careful of her, she's a mad woman," "coo-coo," "nuts," "insane," and "quacky" (Schreiber et al., 1998, p. 514). These labels serve to isolate anyone admitting to or displaying signs of depression. For these women, the stigma of depression was real and immediate. The women in the study handled both the depression and the stigma by "being strong," a basic social process to resolve or improve the problem.

Waite and Killian (2007) reported that a woman's expression of depression will be significantly affected by her cultural identity, culturally endorsed expressions of distress, and perceptions of depression. Understanding the cultural context of depression among African women is essential for health care providers who care for diverse patient populations and could increase opportunities for early detection (Waite, 2006).

Family Relationships

The extended family system generates stress for the immigrant women because it is not uncommon for African women to provide material help for extended family members in their country of origin, as well as psychological and emotional support (USDHHS, 1999). The women share financial resources with extended family members and acquaintances in Nigeria. The immigrant women's financial support assists many people in their country, but this financial burden adds to the stress levels that the immigrant women experience.

As Nigerian-born immigrant women enter the new culture, their cultural orientation is challenged by competing values of the host culture. Nigerian-born immigrant women often experience this change in their daily transactions with the majority group, as well as native African-Americans who do not want to identify with the African immigrants despite a shared racial type (USDHHS, 1999).

Nigerians, like other immigrants, experience a deep sense of loss of their culture, not only for themselves but for their children (Miranda, Siddique, Der-Martirosian & Belin, 2005). Nigerian-born women lament their inability to communicate with their children as they would in their home country, and are pained when their Americanized children fail to learn their language (Kamya, 1997; Miranda, Siddique, Der-Martirsian & Belin, 2005). The prolonged separation from family members in their home country can create gaps in shared

family histories. Family members become strangers to each other, leading to a major strains and disappointments (Kamya, 1997).

The immigrant women hope their children will maintain the strong Nigerian/African cultural heritage and the same commitment to hard work that ensured their own survival in America. However, conflicts between these generations may tear the kinship fabric apart (UDSHHS, 2000). The teenage children of Nigerian-born immigrant women define themselves culturally more as Americans than Africans. The children use an American cultural lens to construct and interpret social reality. The choices made by the children in the areas of clothing, language, music, relationships, and worldview have become major sources of family conflict. The choices made by the children symbolize a rejection of traditionally proven Nigerian cultural values, even though the children may be performing well educationally. The women prefer that the children be selective about elements of the American culture rather than embracing American culture indiscriminately, with unfettered assimilation (Miranda, Siddique, Der-Martirosian, & Belin, 2005; USDHHS, 1999).

Nigerian-born immigrant women may be described as warriors on the outside and butterflies in the inside. They manage depressive symptoms with grace in order to live the cultural imperative "to be strong" (Schreiber, Stern & Wilson, 2000, p. 512). When Nigerian born women migrate to the U.S., various adaptive techniques are use to ensure survival in the sometimes anonymous and

impersonal American system. The women create and tap into networks of social and cultural associations formed to replicate the customs and traditions they left behind in their country of origin. Frequent contacts are made with their family and extended family members in their country of origin. These frequent contacts and interaction with their families provide constant support that sustains the immigrant women (USDHHS, 1999).

An important attribute of Nigerian immigrant women is the development of a deep sense of guarded appreciation for the American ethos that eventually rewards accomplishments. With this in mind, the women navigate through their educational achievements with perseverance and focused goals, and may become competitive in the labor market, and eventually become part of the ethos that defines the American dream (USDHHS, 1999).

To ensure African, including Nigerian-born, immigrant women's survival in the U.S., the women rely on strong kinship bonds and mutual aid associations (USDHHS, 1999). These bonds and associations serve as protection against the persistent racism and discrimination associated with being black and foreign in America. The immigrant women negotiate the terrain of racism by establishing pan-ethnic loyalties that define the context of their relationship to the larger society (USDHHS, 1999). Nigerian-born women, even when they achieve high social status in the United States, remain convinced about one fact. They cannot become full members of the society as long as blacks remain marginalized and

ghettoized, and racism remains entrenched in the American psyche (USDHHS, 1999). Africans, including Nigerians, whether they have come to the United States voluntarily or involuntarily, are perceived as threatening, and as problematic people who have to be either contained or tolerated (USDHHS, 1999). Acceptance of this philosophy by the immigrant women enables them to look for strategies that will help them dwell with the daily hardships of underclass membership (USDHHS, 1999).

Nigerian-born immigrant women's physical and cultural attributes offer them no protection in the U.S. because the women are lumped together into the same white-perceived category of economic and social subservience with African-American-born women (USDHHS, 1999). African immigrants have tried, although unsuccessfully, to differentiate themselves from American-born blacks (USDHHS, 1999).

African immigrant women may be physically present in the U.S., but identify with issues affecting their country of origin (USDHHS, 1999). Permanent residency or naturalized citizenships does not diminish their attachment and affiliation with their country of origin. The majorities of African immigrant women accept the U.S. as their adopted home, believe their stay is temporary, and expect that one day the economic and political conditions in their country of origin will improve, and they will eventually return home. This belief has sustained their mental health (USDHHS, 1999).

Nigerian-born immigrant women lead compartmentalized and restrictive lives; this offers fewer risks and keeps them focused on attainment of goals like higher education, employment, savings, and ultimately, return to their country of origin. According to the Surgeon General (USDHHS, 1999), the immigrant women's strong work ethics have been fundamental in defining hard work, education, self-reliance, and economic empowerment.

Summary

It is important to examine factors that influence Nigerian-born women to seek treatment for depression. Help-seeking behavior remains a problem in the management of depression in this population, due in part to stigma associated with mental illness, and differing illness beliefs. Depression may present as somatic symptoms with cultural idioms of distress in any culture, including ethnic minority groups. Strategies such as the use of trained interpreters, raising awareness, improved communication, a culturally sensitive approach to clinical practice, and various tools and models can help in the diagnosis and management of depression across cultures. According to Ahmed and Bhugra (2006), members of some ethnic minority groups are less likely to seek professional treatment for depression. It has been anticipated that members of ethnic minority groups conceptualize depressive symptoms as social problems or emotional reactions to situations (Karasz, 2006). Combined with the stigma of mental illness, this leads to problems in help-seeking (Ahmed & Bhugra, 2006).

Illuminating the issues surrounding depression in the Nigerian-born immigrant women's population will help health care professionals provide culturally competent care to this group. It is important that health care professionals understand how culture drives a person's behavior. Bhugra and Jones (2001) reported that immigrants who migrate do not leave their cultural beliefs behind. Innate culture and world view follow the Nigerian-born immigrant women to the new country and the cultural beliefs influence their expression of depressive symptoms and help-seeking behaviors (Bhugra & Jones, 2001).

Depression may present as somatic symptoms. The recognition of somatic symptoms of depression and understanding somatic metaphors used to describe distress are important in treating ethnic minority patients. Culturally determined idioms of distress are linguistic and bodily styles of expressing and experiencing depression. According to Ahmed and Bhugra (2006), a working knowledge of these cultural idioms can facilitate diagnosis of depression, establish rapport and minimize the risk of misdiagnosis.

The lack of information in the literature on Nigerian-born women's perspectives toward depression may limit health care professionals' ability to develop strategies for providing culturally competent care. Understanding depression from Nigerian women's viewpoint is a stepping stone to providing culturally competent care to this population. Yoho and Ezeobele (2002) study

suggests that to provide culturally competent care, health care providers will need to understand the cultural norms and boundaries of that population.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT DATA

A qualitative phenomenological study was conducted to explore the perception of Nigerian-born immigrant women's toward depression. The following sections describe the setting, sample, protection of human subjects, instrumentation, data collection procedures, and the data analysis that were used in this study.

Setting

Participants for the study were recruited from the Nigerian community in Houston, Texas. Houston is the fourth most populous city in the U.S. and the most populous city in the southern United States and the state of Texas. Houston is a multi-ethnic city with an estimated population size of 2.14 million (U.S. Census Bureau, 2006). Houston is the third city with largest number of Nigerian immigrants in the U.S. (U.S. Census Bureau, 2006).

Participants

For this study, the sample was purposively selected to obtain rich information regarding Nigerian-born women's beliefs and attitudes toward depression. Participants were self-reported Nigerian-born women, who were at least 18 years of age, who had emigrated directly from Nigeria to the U.S. Participants were recruited for the study until saturation occurred and no new

information was obtained. The participants were recruited via announcements as well as flyers (Appendix B), personal contacts, and word of mouth. When the researcher was provided with the contact information of the women interested, the researcher called the women to provide further information about the study, determine eligibility status, and, if eligible, arranged a meeting time. Participants received $20 at the end of the each completed interview.

Protection of Human Subjects

Institutional review board approval was obtained the from Texas Woman's University Human Subject Review Committee prior to beginning the study (Appendix C). All guidelines for protection of human participants were followed and participation in the study was voluntary as participants could leave the study at any time.

The researcher informed potential participants of any risks (including fatigue, emotional distress, and/or loss of confidentiality) and obtained their consent to participate (Appendix D) and consent to record (Appendix E) prior to the beginning of the interview. The researcher made efforts to minimize these risks. For example, in order to avoid fatigue, participants were offered a break during the interview. If participants became upset regarding the interview questions, they could stop answering any of the questions at any time. Participants' confidentiality was protected to the extent that is allowed by law. Any names mentioned in the interviews were converted into a pseudonym for

confidentiality purposes. To protect confidentiality, the researcher also coded the data, and kept it secured under lock and key at her home.

Data Collection

The researcher established up to an hour-long appointment with each interested participant and conducted all interviews in a private office or room in a home. Prior to starting the interview, the researcher reviewed and explained the consent forms and the study with the potential participants. Following the completion of consent, demographic data were collected using a pre-interview questionnaire (Appendix F). The researcher conducted a semi-structured audiotaped interview, using open-ended questions with each participant (Appendix G). The participants were asked to describe their perception towards depression. A professional U.S.-born transcriptionist transcribed the audiotapes. The researcher also returned for follow-up appointment for validation with several participants.

Instruments

The instruments used in this study were a demographic data form and a semi-structured interview guide developed by the researcher, which was tested and evaluated in a pilot study. The researcher obtained demographic information such as participant's age, dialect spoken, level of education, year immigrated to the U.S., career or employment, number of children and age(s), and marital status. Interviews followed a semi-structured format which consisted of questions

developed by the researcher based on gaps identified within the review of literature about the immigrant women.

Interviews were scheduled at a time and in a location that was convenient to the participant. The researcher explained the study, obtained consent, and conducted all interviews. The researcher obtained permission from the participants to return for a follow up interview if needed for validation of information. The interviews were conducted in a private room with only the participant and researcher present. The researcher turned on two digital tape recorders and used the semi-structured questions to guide the interview. The researcher used probe questions throughout the interview process to gain more information and seek clarifications from the participant. The participants described their views about depression. The open-ended interview lasted 45 to 60 minutes. At the completion of the interview, the researcher thanked the participants and gave them $20 for participating in the study.

The following questions and probes were derived following analysis of data from a pilot study. The questions were as follows:

Q1: When you hear the word depression, what does that mean to you?

Q2: When you were growing up in Nigeria, what attitude did you have towards depression?

Q3: When Nigerian-born women in the U.S. seek help for depression, who do they go to for such help?

Probe: What will prevent them from seeking help?

Probe: What will help them seek help?

Q4: What are your personal experiences of depression?

Probe: What helps?

Probe: What makes it harder?

Q5: When you think of depression experiences, what are the differing beliefs held in the U.S., from those held in Nigeria?

Data Analysis

Theoretical underpinnings of Husserl (1962, 1970) guided the analysis. Specifically, data collection continued until a thick description of the phenomenon was obtained and no new themes emerged. The narrative texts were analyzed and interpreted using Colaizzi (1978) seven steps:

1. All interview transcripts were read to obtain a "sense" for them.
2. Significant statements were extracted from the verbatim transcripts.
3. The meaning of the significant statements was formulated.
4. The formulated meanings were organized into clusters of themes.
5. The themes were referred back to the original interviews for validations.
6. Discrepancies were noted, and the researcher avoided any temptation to ignore data that did not fit.

7. The results were integrated into an exhaustive description of the phenomenon and 50% of participants were asked to read the researcher's interpretation of their narratives from the interviews for validation.

Step 1 is a process whereby the researcher read all the transcribed participants' descriptions in order to acquire a feeling for them, and make sense out of their responses. In step 2, the researcher returned to each transcript and extracted phrases or sentences that directly related to the investigated phenomenon of depression. Several transcripts contained the same or nearly the same statements and the researcher kept notes on these statements. The researcher kept a complete listing of the extracted significant statements from the data. In Step 3, the researcher examined each significant statement and began to formulate meanings.

In step 4, the researcher repeated steps one through three for each transcript and organized the summative formulated meanings into clusters of themes. The researcher allowed for the emergence of themes found common to all the participants' transcripts.

In step 5, the themes were referred back to the original transcripts for validation. The researcher achieved this by checking if there was anything contained in the original transcripts that were not accounted for in the clusters of themes.

In step 6, the researcher noted discrepancies and avoided excluding data that did not fit. In step 7, the researcher integrated the results of the preceding data analysis into an exhaustive description of the phenomenon under investigation. The researcher formulated an exhaustive description of the investigated phenomenon depression. Step 7 was also the final validating step in which the researcher returned to fifty percent of participants to read the researcher's interpretations, and incorporated new information from them into the final description of the women's perceptions of depression.

In this study, the researcher used critical reflection throughout the whole research process to increase open-mindedness. Husserl believed that experience, as perceived by human consciousness, has value and that subjective information ought to be important to scientists seeking to understand human motivation, as human actions are influenced by what people perceive to be real (Lopez &Willis, 2004). Demographic information was analyzed using descriptive statistics.

Scientific Rigor

An important aspect of this study was to ensure trustworthiness in the study. The researcher established thoroughness by demonstrating trustworthiness and credibility within the context of the study. According to Koch (1995), it was the responsibility of the researcher to reveal how this study tackled the issue of trustworthiness and it is up to the readers to judge credibility.

Credibility

Credibility refers to confidence in the truth of the data and interpretations of them (Polit & Beck, 2004). Lincoln and Guba (1985) point out that credibility involves two phases. The researcher conducted the study in a way that enhanced the believability of the findings, and she took certain steps to demonstrate credibility to the participants. The participants are the only ones who can legitimately judge the credibility of the results. According to Lincoln and Guba (1985), the researcher must invest sufficient time in the community to learn the culture and test for any misinformation introduced by distortions, either of the researcher or of the participants, and building trust.

In this study, the researcher ensured credibility through prolonged engagement and persistent observation in the Nigerian community in Houston, Texas. The researcher, a Nigerian-born immigrant woman, had spent time in the Nigerian community before the study began and this linkage allowed trustful relationships to develop between the participants and the researcher. Credibility was also ensured when the researcher went back and listened to each tape transcribed to uncover the missing data that were identified by the U.S.-born professional transcriptionist as, "inaudible" on the transcripts and corrected the missing information on the transcripts.

Dependability

The dependability of qualitative data refers to the stabilization of data over time and over conditions (Polit & Beck, 2004). It is based on the assumption of replicability or repeatability and whether the same results would be obtained if the researcher observes the same thing twice. Dependability is used to assess trustworthiness in qualitative research. A technique used to ensure dependability is an inquiry audit. An inquiry audit involves a scrutiny of the data and relevant supporting documents by an external reviewer (Polit & Beck, 2004).

In this study, the researcher used a purposive sampling technique to recruit participants. The researcher consistently used the same in-depth, open-ended questions, to collect data during each interview and, two tape recorders were used to prevent loss of data. The researcher ensured these tape recorders were reliable for recording human conversation prior to the initiation of each interview.

Confirmability

Confirmability refers to the degree to which the results could be confirmed or corroborated by others (Lincoln & Guba, 1985). In this study, the researcher established two strategies to ensure confirmability: (a) bracketing, and, (b) keeping an audit trail.

Bracketing in phenomenological inquiries is defined as the process of identifying and holding in abeyance any preconceived beliefs and opinions about

the phenomena under study (Polit & Beck, 2004). Bracketing helped the researcher to understand the effects of her experiences, rather than expending energy trying to eliminate those experiences (Polit & Beck, 2004). Bracketing cannot be achieved totally, but the researcher sets aside any presuppositions to the extent possible in order to confront the data in pure form. An integral part of Husserl's descriptive phenomenology was for the researcher to bracket preconceived ideas about the phenomenon under study. It is also important that readers are aware of the researcher's background and experiences.

In this study, bracketing was achieved when the researcher ensured that she clarified her personal values, identified areas of possible role conflict, set aside any preconceived beliefs or opinions about the phenomena under study and did not detract from understanding the essential view points of those being studied. The researcher's professional history along with personal experiences and direct quotations from participants' interviews during analysis, added to the trustworthiness and credibility of the study. Additionally, the researcher has an obligation to present and report her investigative procedures and processes as fully and truthfully as possible (Patton, 2002). The researcher conducted the study by taking necessary steps that enhanced believability of the findings and demonstrated credibility to the consumers (Lincoln & Guba, 1985).

Audit trail was the second strategy the researcher used to ensure trustworthiness. Audit trail is a transparent description of the research and steps

taken from the start of the research project to the development and reporting of findings (Lincoln & Guba, 1985). The intent of an audit trail is that an auditor follows what the researcher has done and performs checks required to ensure and assure the quality of results (Polit & Beck, 2004).

In this study, each time the researcher made what was considered significant changes to the text, a copy of the old word file was kept. The researcher used reflexive journal to record her intentions and dispositions. Reflexive journal is a systematic collection of data and documentation that allows an independent auditor to come to conclusions about the data (Polit & Beck, 2004). The independent auditor the researcher used for this study to establish trustworthiness was a TWU faculty. Raw data, including field notes and interview transcripts regarding the investigation process, were kept in a safe location for future use or reference (Malterud, 2001).

Transferability

Transferability refers essentially to the extent to which the findings can be transferred to other settings or groups (Polit & Beck, 2004). Lincoln and Guba (1985) discussed the concept of transferability as the extent to which qualitative findings can be transferred to other settings, another aspect of a study's trustworthiness. It was the researcher's responsibility to provide thick description about the contexts of the study (Lincoln & Guba, 1985).

In this study, the researcher was insightful of the type of groups to whom the results of the study might be transferred to, and she used a purposive sampling technique to select study participants from the Nigerian-born immigrant women's population. The researcher provided a rich and thorough description of the research setting and the processes so that the utility of the evidence for others can be assessed. Each recorded interview was transcribed verbatim and compared to the completed transcriptions to ensure that the transcribed information was valid and accurately described in the final analysis. The researcher's detailed description made transferability judgment possible for potential appliers and ensured trustworthiness of the study.

Pilot Study

A pilot study was conducted in spring of 2007 to test the feasibility of the study and validate the length and number of interview questions. The overall purpose of the pilot study was to explore the perceptions of Nigerian-born immigrant women towards depression. Permission to conduct the pilot study was obtained from Texas Woman's University Institutional Review Board (IRB). A sample of four Nigerian-born women participants was recruited for the pilot study and participants' age ranged from 25 to 72 years. Three of the participants identified themselves as married, and one was widowed. The participants' length of stay in the U.S. was five years or fewer. Two of the participants held a

baccalaureate degree from Nigeria; one was a retired nurse, and, the remaining participant was a business woman with a high school diploma.

The pilot study evaluated the quality of the data collection methodology including the semi-structured interview guide, the interview process, and data analysis. All the four women participated in direct, audiotaped interviews. The use of a semi-structured interview process allowed accurate data collection and analysis of the perceptions of depression by Nigerian-born women. The analysis of the data resulting from the interviews provided an understanding of how the women's cultural beliefs drive their behaviors and perceptions of depression. The interview process, with the probe questions, clarified the information that emerged during the semi-structured interviews.

Demographic questions included level of education, current employment status in the U.S., previous employment in the home country, marital status, and number of children. The number of years lived in the U.S. was added to better describe the Nigerian-born women sample. From the preliminary pilot study findings, it was concluded that the researcher would continue to use the semi-structured interview questions with minor modifications for the larger study.

CHAPTER IV

ANALYSIS OF DATA

A phenomenological approach was used to explore the meaning of depression in Nigerian-born immigrant women who live in the United States (U.S.). Semi-structured interviews used for data collection were audiotaped and then transcribed to identify emerging themes. The interview responses represented what was real to these women and provided data for the study. This study sought to acknowledge a previously overlooked immigrant population. Knowledge gained from this study may enable health care professionals to better understand the viewpoint of Nigerian-born immigrant women of depression and may facilitate in the provision of culturally competent care to this population.

This chapter describes the sample of Nigerian-born immigrant women who participated in the study and documents the responses to three research questions (RQs):

RQ1: What does depression mean to the Nigerian-born immigrant women?

RQ2: How do Nigerian-born immigrant women perceive depression?

RQ3: What methods are used by Nigerian-born immigrant women in the U.S. to treat depression?

Themes derived from the participant responses to these questions are discussed and a summary of the findings is presented.

Description of the Sample

Nineteen women participated in the study. The women ranged in age from 26 to 71 years, with a mean age of 49.4 years (*SD* = 12.9). The participants' place of birth in Nigeria varied. The participants most common place of birth was Abia state (*n* =4), Anambra state (*n* = 2), Cross River (*n* =1), Kano state (*n* = 3), Imo state (*n* =1) Lagos state (*n* = 2), Ondo state (*n* = 2), Plateau state (*n* = 2), and Rivers state (*n* =2).

The women's educational data indicated that a majority of the women (68% or 13 of the 19) had a college degree. The educational breakdown is as follows: Master's degrees (*n* = 6) bachelor's degrees (*n* = 7), nursing diplomas (*n* = 3), and the remaining three had high school diplomas. The participants' length of stay in the U.S. ranged from 5 to 32 years, with a mean of 16.1 years (*SD*=10.4). Marital status data revealed that 13 participants (68%) were married, 3 participants were widowed, one was separated, and the rest were single. The number of children by each participant ranged from two to seven, with a mean of 4.5 children (*SD*= 1.5). The ages of the children ranged from 1 to 50 years. Two of the participants did not have children. The most common dialect spoken by the women was the Ibo language, and some of the women spoke multiple dialects. Of the nineteen participants, fifteen spoke the Ibo language, two spoke Yoruba, and the rest of the women spoke the Ibibio, Efik, Hausa, Kalabari and Ogbia languages. The majority of the participants (*n* =17) had relatives who live in the

U.S., but, two did not have any relatives in the U.S. Participants worked in a variety of settings located throughout Houston, Texas, and surrounding suburbs. The employment status of the participants was as follows: full-time (*n* = 12), part-time (*n* = 1), retired (*n* = 1), student (*n* = 2), and unemployed (*n* = 3).

Methods

Each transcript was read multiple times and the interview tapes were reviewed to ensure accuracy of transcription, and to achieve a total understanding of the phenomenon. Summaries of each transcript were written in search of potential themes. A comparative analysis of the transcripts identified significant words that were highlighted and finally grouped into themes that cut across the texts and reflected participant responses in the three research questions. Each research question generated a set of themes.

Prior to the finalization of themes, the researcher returned to ten participants to validate the interpretations of their narratives. Seventy significant statements (Appendix H) were extracted from the transcripts. From the interviews and from these statements, the researcher derived formulated meanings which led to the identification of six theme clusters.

Following validation with the women, themes were connected and described using the most recurrent participant narratives. One faculty member from Texas Woman's University reviewed the themes and supportive narratives to add further validation to the study findings.

Findings

The narratives of Nigerian-born immigrant women's perceptions toward depression are presented in this chapter with a description of patterns, themes, and sub-themes (Appendix A) discovered during data analysis. This study uncovered one overarching theme, three patterns that spanned six themes, and 18 sub-themes. The overarching theme, *Depression is Not Acceptable*, was implied over and over again by the women throughout the interviews. The three patterns were: *Incurable and Untreatable, Stigma,* and *Cultural Influence*. Each pattern is described in more detail.

Pattern: Incurable and Untreatable

The researcher first asked the 19 women to describe what depression meant to them. Incurable and untreatable were terms used specifically by ten of the participants but reflected a definite pattern among all respondents. The explanations provided by each participant were clustered into one of two themes, with some overlap: craziness and madness, and curse and evil spirit possession

Theme 1: Craziness and Madness

The participants described depression-like symptoms as craziness and or madness. The women could not differentiate depression and its symptoms from other types of mental illnesses and described any psychological problem as mental illness. A participant, Chi Ofuma (all names used are pseudonyms), a 70-year-old widow, mother of six children, who came to the U.S. five years ago, and

holds a nursing diploma, emphatically stated, "You people in the U.S. call it depression, we call it madness in Nigeria." Another participant, Shade Ademu, a 36-year-old married mother of three children, who came to the U.S. five years ago, holds a bachelor's degree from a Nigerian university, and is currently a nursing student, explains that, "Depression goes to the head and causes scatterbrain and any woman with any kind of psychological illness is labeled as either mad or crazy." A participant, Rima Dikko, a 60-year-old widower, mother of four who came to the U.S. five years ago, holds a Master's degree, was a professor in Nigeria, and is currently unemployed in the U.S. states,

> Depression makes me reflect on somebody who is extremely withdrawn, isolated, sad, uh.... Does not communicate with others effectively, and lacks cooperation .....Back in Nigeria somebody would say the affected woman is crazy or the person is becoming mental um... because the word depression is not effectively understood in Nigeria because people would rarely say somebody is depressed. The person is either mad or um... you're looked at as a weird person. So... when you come across somebody who is opposite of what the society considers normal, you are just a weird person and your family will be worried.

A participant, Nkiru Odu, a 51-year-old, married, mother of four, who came to the U.S. 11 years ago, and holds a bachelor's degree, and is currently a nursing student, explains,

> When somebody is doing something that deviates from the norm, people don't look at it as depression..... we generalize everything once it is out of the ordinary, we think there is something wrong with this person upstairs (pointing to her head to explain the meaning of upstairs). Upstairs have something to do with mental illness and once the word is used, it is known in the community and that's the literal meaning for crazy or madness.

Fifteen participants reported that, "depression is a sign of weakness," however, four did not mention weakness. One of the participants, Lidya Odu, a 26-year-old, single female who came to the U.S. 17 years ago, and holds a bachelor's degree explains,

> A typical Nigerian-born woman is supposed to be strong not just for herself, but also for her family and uh-----you just cannot be depressed Depression is a sign of weakness to a Nigerian-born person. You are supposed to be strong, not only to yourself, but for everybody outside looking onto you and for your whole community.

A participant, Apuna Anwu, a 49- year-old, married, mother of four, who came to the U.S. 24 years ago, and holds a bachelor's degree, reiterates that

> Growing up in Nigeria you're taught to pretend like if you're not hurting, you know, don't show it because it is more or less like a sign of weakness and we call it crazy. Culture is something that is very strong and that's what people here in the U.S. will really understand and give room for

people to really be who they are, because your upbringing has a lot to tell who you are. Like I said, that upbringing is what that made me strong to be able to survive in this country and be where I am. Really, if not for that strong upbringing of my culture, I probably uh…would be crazy. Going through what I went through especially in nursing school, I would have become one of the statistics of crazy person, you know, and because of my state of origin, nobody in this society will care about you because I am a foreigner and I won't forget that.

A participant, Oma Okwu, a 46-year-old, married, mother of four children, who came to the U.S. 26 years ago, and holds a bachelor's degree in nursing, explains,

> Usually when you say depression…they're like somebody crazy, you know, somebody having problems with the brain or something and uh, I remember back home, I didn't know the name depression, but I know they generally called them crazy. Some of them will be on the streets naked or with a piece of rag covering their private parts and all of us will be running, you know… that the crazy woman is coming.

For example, a participant, Ihuoma Egbu, a 48- year- old widower, mother of six, who came to the U.S. 24 years ago and holds a Master's degree, states,

> The woman and her family will be labeled crazy by the community, and um… it's not a good thing to associate with in Nigerian families. You do not want to be classified as mental, you know…now you are crazy.

Rima Dikko concludes that, "Your family will look for solutions and try to understand what the problem is with the woman and they will regard you as a possessed person."

Theme 2: Curse and Evil Spirit Possession

The participants associated the origin of depression with evil spirits, water spirits, and demons. All of the participants expressed a conviction that depression is a curse that can be inflicted by one's enemy, evil spirit, or voodoo. Similarly, Shade Adamu, further elaborates,

> Witches and wizards are responsible for inflicting depression in a person through witchcraft. I came from a place in Nigeria where witches confess their evil deeds and I have personally heard witches confessed how they inflicted depression on a woman in my village and she became mad. I have the strong belief uh… that the cause of depression is evil spirit invoked by witches and one's enemies. I don't think I can ever change my mind about depression because it is evil and evil controlled. Any family with depression is linked to evil spirit controlling that family.

A participant, Amaka Onu, a 53-year-old, married, mother of five, lived in the U.S. for 28 years, and holds a diploma in nursing, explains,

> Depression is a curse placed by the enemies. Enemies of their grandparents, enemies of their forefathers, or maybe something their forefathers did that was not right with their gods. In those days, they have their own gods and if they did not appease their gods, then it would be a curse on that family.

Oma Okwu spoke freely about her beliefs:

> Something like mental illness is an abomination you know, it's something that, uh, that doesn't worth ... discussion about or talking in our community. When somebody is acting, you know, differently like that, uh... is being considered abnormal, family will try to find out if someone is doing something strange, I mean, doing something bad to the individual to act that way. They are going to attribute that person's behavior that uh, somebody is trying to make the person act strange, you know. There is always belief that, uh... when someone is mentally, uh, having mental breakdown or problem, that something bad somebody did to the person.

Rima Dikko states, "A person with depression is regarded as somebody possessed by water spirits, or demons." Also, a participant, Chioma Dike, a 62-year-old, married, mother of five, who came to the U.S. 31 years ago, and holds a Master's degree, commented,

> The problem I am having right now, back home they will say that it is dual spirit from the waters or the offenses you forefathers committed that came

> back to hunt you, or "ogbanje" that has made you to behave that way or evil forces from any part of occult has come to hunt you. Or that something you did in your first life, uh… they believe in life after death and that somebody who has lived a life and come back to life, so what you didn't do right in the first life are now hunting you. "Ogbanje" back home is said to be somebody living a dual life, coming in contact with water spirits, or mountain spirit, or thunder spirit will hunt the person and they uh…so when you start misbehaving, they say it is "ogbanje" and the forces against you now are from "ogbanje." They believe in all these gods that is combining now with your human god to hunt you because you are not working in compliance with the gods.

Chioma Dike further explains the meaning of compliance and the functions of the gods as

> If you're not agreeing or dancing to the god's music and not doing what they have asked you to do, the gods come against you and start fighting you. Either, it may be the water spirits, the mountain spirits or the thunder spirits that is working against you and that's why you are no longer functioning as a normal person. You get uh… depression or what they call mental sickness and that's what causes…… other spirits working against you will make you have depression. Nigerian-born woman still believe that

> a woman who just...not from birth is depressed, is caused by somebody and or evil spirits.

Ihuoma Egbu, explains that

> It is a common thing here in the U.S. to see people in this culture go to the doctor and discuss their symptoms but in our Nigerian culture it is not perceived that way. It's either somebody is doing voodoo, like the native doctor is responsible, a curse or the witches are causing the depression and you know, um, there is a force out there that is causing this to happen.

Similarly, a participant, Chinyere Onu, a 58-year old married mother of two children, who came to the U.S. 28 years ago, and holds a Master's degree, states,

> The spiritual notions of depression among the Nigerian-born women hold much weight. One belief is that somebody suffering from depression is under the influence of the devil or spiritual being. People look at it as inflicted by outside sources or a curse and that is the explanation.

Pattern: Stigma

The stigma of depression was seen as being strong enough to transcend any social status that exists. The women identified stigma as a strong force in the Nigerian culture which not only affects the woman suffering from depression, but also her family, and extended family. All of the participants used the term stigma

and discussed how the stigma of depression affects break-up in marriages, prevents marriage, and affects one's status in the community. One participant stated that, "Once you agree you are suffering from depression, that is the beginning of your downfall in the Nigerian community," and "people will talk about you and point their finger at you in any social gatherings." The narratives expressed by each participant were clustered into one of two themes with some overlap: denial and secrecy; isolation and rejection. Garff (2005) quotes Kierkeguard, the great philosopher, "Once you label me, you negate me."

Theme 1: Denial and Secrecy

Denial and secrecy was a theme that emerged from the second research question. Denial and keeping an illness secret are strong forces in the Nigerian culture. Using denial and secrecy allows ill persons to blend into the larger Nigerian community. Although, the participants were willing to describe their thoughts about depression, most participants made it clear that depression or depressive feelings did not pertain to them. Some of the women expressed their experience with depression, but refused to seek professional help for fear of being labeled with mental illness. Despite their despair, the women continue to assure themselves that they cannot suffer from depression. Lidya Odu explains,

> There is nothing call depression in Nigeria, I only heard depression when I came to the U.S. You are supposed to be a mother, a wife, and there is no time for anybody to suffer depression. This is not considered a disease

like cancer or diarrhea. Depression does not exist. Why should someone be depressed? We will always deny depression and suffer in pain.

Lidya Odu continues that the stigma and taboo associated with depressive illness in Nigerian culture often results in the women masking their problems by focusing on their physical symptoms.

> I have suffered depression, but maybe not in heavy or strong doses but in little doses. Ask a typical Nigerian woman suffering from depression if she is depressed, she will give you a good answer. She will say my head hurts, my heart hurts, my whole body is shaky, pressure on my chest, and my head is empty, burning sensation all over body, aches and pains all over, heavy legs and pressured body. So it is expressed in a physical way which is not clearly understood. It is easier for a Nigerian-born woman to go to her physician and talk about their body. They are not comfortable expressing their emotional thoughts and feelings. The emotional problem always manifests in a physical way, because the physical part is more socially accepted in the community. We do not accept mental illness and the woman will never tell you she is depressed.

Oma Okwu expresses her thoughts as

> I don't think a Nigerian-born woman would just go to the doctor and admit she is depressed. She would not even admit it in the first place. Somebody will really, really push you if it gets to that point...that person

> may be trying to kill herself or something and somebody has to call 911. For somebody to voluntarily go to the doctor to seek uh...mental health attention, I don't know, I wonder. I've been here for 26 years and I know if even I am depressed, I don't think I'm going to go...uh, I still have that cultural belief, you know, it's like opening your dirty laundry out there and they would be talking about you in this society and you know...oh, did you hear that, that person is going crazy, uh crazy, kind of scary. If I get...I don't think I would be seeking uh ... for the doctor. It's kind of strange that, uh, I think it has something to do with culture. Even if you are in the U.S., you know, that cultural influence is still there, I mean, we have our own communities, so you hear what is happening.

Chioma Dike, reports,

> First of all, the woman will deny she has depression because it is so belittling to hear that language...the phrase or mentally sick. As a result, they keep it secret and would not want uh... like someone else to know about it and don't seek treatment. As a result to make sure that nobody ostracizes them, they just hide it.

Theme 2: Isolation and Rejection

All the participants explained that exhibiting or admitting to depression would contribute to isolation and rejection in the community. Each participant described that they believe Nigerian-born women will not seek treatment for

depression because of stigma attached to the illness in their community. The participants explained that Nigerian-born women's emotional suffering may begin due to certain circumstances, however, they would not seek treatment because of the "stigma," "shame," "fear of losing face," "pride," and "moral accountability." The participants alleged that Nigerian-born women maintain silence with no emotional outlet, accepting and enduring symptoms of depression as a way of life, while at the same time, attempting to search for solutions to deal with their despair alone. Throughout the interviews, a recurrent concept was that persons are aware of their moral duties and cultural obligations in the Nigerian community. Most of the participants concluded that in their culture, certain social norms and expectations must be observed. For example, any person running around naked and attacking others without a cause becomes an outcast. Remi Dikko mentioned that the stigma of depression interferes with marriage and causes marital conflicts in families and commented that, "nobody wants to reveal they have depression because they are afraid they would be considered mad and will hinder marriage for their children." Similarly, Shade Ademu explains,

> Even in marriage, we do not marry into a family with a history of mental illness will prevent marriage from occurring. During courtship, the families investigate each other for history of depression. Any positive history, the marriage will not take place. This is cultural expectations and

requirements for all marriages. This prevent producing off-springs with depression.

A participant, Amaka Onu, a 53-year-old, married, mother of five, who came to the U.S. 28 years ago and holds a nursing diploma added,

> Everybody in that family is marked with that stigma, nobody wants to go to their family to uh… choose a girl for marriage and nobody will allow any man from that family to marry their daughter. You know… I mean this will go on generations after generations.

Ihuoma Egbu gives an example of what happened in her village to the female children in a family where a woman suffered from depression in 1947:

> A family in my village has lots of female children that were unmarried and when the hereditary was traced, it was found out that their great, great, great grandmother in that family suffered depression or madness in 1947 so that's why nobody is marrying the women. The men from that family were getting married quite alright to outsiders who are not from their culture. This is affecting the family from generation to generation. It is a very serious issue when it comes to Nigerian culture... Nigerians do not play with this issue. If you admit to depression, that's the beginning of your downfall in our community.

All the participants explained that they dread the word depression because their ancestors have rooted these cultural beliefs in them that are difficult to erase. Ihuoma Egbu explains,

> I will be skeptical for my child to marry from a family that has a history of depression to prevent her from having children who will be constantly depressed and crazy. I don't think I will want my child to marry from such a family because depression is difficult to erase. I guess our culture is still here with us, no matter how educated you might be, we still have our beliefs.

Rime Dikko explains the stigma and fear of transference of depression to your kids,

> It is not only the stigma of depression that we fear, but the utmost fear is fear of transference that may occur from generation to generation. A lot of people believe that mental illness is transferable, depression is transferable. One abnormal person in the family may lead to another abnormal person in that family and you do not want to transfer this illness to your children.

All the participants explained that the social norms in the Nigerian community are very strict and concrete, and any deviations from these norms are not acceptable. Shade Adamu explains,

> Any woman who deviates from these norms is rejected by her friends and the community. People suffering depression should not be allowed to socialize with normal people. I would not like to associate with any woman suffering from depression so other people will not think that I have depression. You know... birds of the same feathers fly together.

Reiterating isolation and rejection, participants used adjectives such as "aggressive dog," "madwoman," "curse from the gods," "infliction by evil spirits," to describe depression. Shade Adamu expressed that

> Nobody goes to the compound of a woman suffering depression. The woman is just like an aggressive dog in your house that prevents visitors. The madwoman is an aggressive dog that must be contained by chaining to protect others.

Uju Aku, a 49-year-old, married, mother of four, who came to the U.S. 27 years ago, and holds a Master's degree, describes a person suffering from depression as

> A tree planted but under the root part it is like cankerworm that's eaten it apart. Like a hole and you are inside that hole and you are saying get me out of here, and people are passing by and nobody is getting you out of that hole.

Lidya Odu concluded by using an analogy to drive her point and states that

> Depression is seen as leprosy or AIDS, like in those days in the Bible when you have leprosy, people would not want to eat with you. If you tell somebody you have depression, people would not want to sit with you because they're afraid it will carry on to them.

The participants explained that, for a family to maintain integrity and social acceptance in the community, maintaining social norms and social status are more vital than the individual in the Nigerian community. The participants explain that a family member would not want to be identified with the depressed woman for fear of being ostracized from the community. Shade Ademu states that, "If you are depressed or mad, you are isolated in your room or at a corner in your compound with chains on both legs to prevent the woman from leaving the compound."

The cultural belief among all participants is that when a woman suffering depression is not chained and she ends up in a market square, the depression becomes incurable. Amaka Onu commented that

> They lock them up and uh... and throw their food on to them, and uh...they don't go there to communicate with the person. The family just opens the door and throws their food or drink at them. We have one in my village, this girl uh, was mentally ill, so the family kept her in a locked room. Often times as we pass by, we would hear her screaming and

crying and nobody went to her. The only time somebody went to her was when she is to be fed or taken to the bathroom. Her legs were chained so she would not run away to the market square.

Pattern: Cultural Influence

The researcher asked the women to describe the methods used by Nigerian-born immigrant women in the U.S. to treat depression. All 19 participants identified religion as the most common approach used by the women in the treatment of depression. Each woman verbalized that prayers and fasting have helped in curing other Nigerian-born women who suffered depression in the U.S. The women expressed that clergy is the first point of contact for treatment of depression and are preferential to health care professionals. The feeling expressed by each of the participants was the need for education. One woman stated, "Educating the Nigerian community about depression will help them understand the illness and seek for treatment." The descriptions expressed by each participant were clustered into one of two themes, with some overlapping spirituality and religion, and the need for education (see Table 1).

Table 1

Overarching Theme, Patterns, Themes, and Sub-Themes Representative of 19 Nigerian-born Immigrant Women

Overarching Theme	Patterns	Themes	Sub-themes
Depression is Not Acceptable	Incurable and untreatable	Craziness and Madness	"Depression is no different than more serious mental illnesses"
			"Depression is a sign of weakness"
		Curse and Evil Spirit Possession	"Depression can be inflicted by witches or others"
			"Ogbanje" (meaning dual personality from water spirits)
	Stigma	Denial and Secrecy	"Depression does not exist"
			Physical symptoms can be recognized
			Fear people will find out
		Isolation and Rejection	Shame
			Fear of losing face
			Entire family rejected
			Transferred to children
			Prevents marriages
			Friends reject
	Cultural influence	Spirituality and Religion	Belief in higher power for help
			Fasting, prayers, and spiritual deliverance are treatments
		Need for Education	Recognize depression as a common problem
			Nigerian culture presents barriers to treatment

Theme 1: Spirituality and Religion

Spirituality and religion play a crucial role in helping Nigerian-born immigrant women cope with depressive symptoms. The belief in higher power for dealing with life's hardships has been a source of strength for the women. The participants believe that fasting, prayers, and spiritual deliverance are treatments of choice and preferential to consulting health care professionals. Although data was not collected on specific religious affiliation, most of the participants used the word "God" when discussing religion. Additionally, many of the participants referred to a Christian philosophy when discussing their perception. The women clarified that the treatment for depression consisted of seeking God's solace. The women believed that the framework for understanding and treating depression was grounded in Christian doctrine. Spirituality was believed to be central in Nigerian-born women's lives. All of the participants agreed that Nigerian-born women depend on God to cure this affliction. Remi Dikko expressed her spirituality and beliefs freely,

> Most Nigerian-born women suffering from depression go to their clergy for prayers and spiritual deliverance. You know, spirituality plays a big role in a person's mental health in my culture. The clergy is our first point of contact for treatment and our clergy will keep your problem confidential, unlike health care professionals' approach that does not include religion and moreover, health care professional will not keep your illness

> confidential. Once you see a health care professional, you become labeled with mental illness, your insurance company will know, your job will know...

Similarly, Shade Ademu states that, "Depression is curable if the individual is religious and as a Christian, I rely on spiritual warfare to cast out this illness." Chi Ofuma contends that, "The cause and treatment of depression are situated within God's plan and depression is spiritual and therefore, you must use spiritual means through prayers, fasting and pastoral counseling to cure it." All the participants established that having strong faith in God will help someone suffering from depression combat the illness. Shade Ademu quoted some Bible verses and concludes that

> Prayers can do a lot and in many cases prayers solve the problem. You must depend on God to chase out the evil spirits. The Bible says we do not war against flesh and blood, but against principalities and the rulers of darkness.

All the participants agreed that the historical importance of spirituality lays its role in providing emotional comfort when suffering from depression. Uju Aku reveals how she deals with depression by combining faith, meditation, prayers, and solitude:

> I think I was depressed because I was constantly feeling sad, especially when my father and mother died. I was crying a lot, and even though I was

not diagnosed with depression. My faith kicked in and I was able to handle this problem with faith. I became connected with God through the women's bible study group in my church. I prayed, fasted and believed that our faith is the strength that we have, a substance of things we hope for and evidence of things we have not seen. Going to church was the only way I found my sanity. The word of God said, 'the joy of the Lord is our strength.' So, I am weak because they are weak. The Bible study and prayers is a spiritual way to strengthen one's faith or the spirit that was weakened.

Many times during the interviews, the participants referred to God, faith, prayers and fasting. Nkiru Odu further expressed that, "an inclusive healing approach for Nigerian-born women is to inherently not allow themselves to become depressed and I don't allow myself to get depressed and I pray to God that I never get that way." Seventy percent of the participants became animated during interviews as they describe their divine healing. The participants are noted to feel strongly about what they are saying. It was common to see the participants reference God by doing a sign of the cross on their forehead and chest as they describe God's rescue of them from symptoms of depression.

Theme 2: Need for Education

A shift in attitude occurred among the nineteen participants as they verbalized tremendous need for education on mental health issues for the

Nigerian community in the U.S. The participants self-initiated the importance of understanding the physiological components and causes of depression. All participants wondered why ancestral beliefs are rooted so deeply in their culture. Nkiru Ndu states,

> The women in our community need a lot of education, and constant communication with people who work in psychiatric facilities. A real U.S.-born person would not regard depression as shameful. It is regarded as an illness here and could happen to any person regardless of socio-economic status, race or creed.

Similarly, Remi Dikko contends that the Nigerian community needs education for mental health problems. She expresses that treatment for depression in the U.S. is "brain-based," while in Nigerian culture, it is "emotion-based." Fifty percent of participants described a strong belief in using rituals and fetish means for the treatment of depression in Nigeria, and they express that providing education for the Nigerian community here in the U.S. and back home in Nigeria, will help eradicate these types of fetish treatments. Remi Dikko elaborates further that

> In Nigeria today we have some highly educated, we have those with minimal education and those without education. Those without education use the traditional and fetish ways such as juju priests for treatment of depression. The priests use all kinds of treatment, like monkey heads and silent animals, um... turkey, all kinds of shell, which they grind and dilute

> the powder in a drink and give to the woman to drink. Yeah… sometimes you see somebody who is really sick wearing the skull of a monkey or turkey as pendant. Those with minimal education combine both traditional extreme and medical extreme. In the U.S., the women who suffer depression do not go to the hospital because of shame, the stigma of being regarded as mad.

Nkiru Ndu contends she has learned a lot about depression since coming to the U.S.,

> A person with depression is ill, just like somebody with high blood pressure, or diabetes. They need love, compassion, and treatment. Providing education will help Nigerian women understand depression is an illness. And if you take your medication as prescribed, you can live with the illness.

Similarly, Lidya Odu further explains that since she came to the U.S. and learned about depression, she realized that it is high time for Nigerians to

> Revamp Nigerian culture by doing some editing, because there are things from our ancestors that are rooted in the culture that we need to let go. If it comes to medical issues, we should not say because of culture and not take care of ourselves and die in silence.

Chinyere Ono agreed that, "depression is a normal thing that could occur over a course of a lifetime depending on what the person is going through at that time." Remi Dikko contends that education is needed to, "take away this satanic

brainwashing; training will help us gain skills and coping mechanisms to use, and will also, provide awareness that seeking treatment is not weakness, but a strength." Apuna Anwu explains that education is important, and added,

> I must not fail to tell you that the way you grew up never leaves you, your culture never leaves you and I have to be sincere about that; I am very skeptical to have my child marry somebody with depression.

All the participants conclude that education will help the Nigerian community and Nigerian-born women become knowledgeable of the different types of mental illnesses. Oma Okwu explains that, "nobody knows the differences between you are depressed, and you did not take care of yourself or that you are hearing voices and hallucinating like in schizophrenia." All participants state that providing education about the different types of mental illnesses is important public health enlightenment for the Nigerian community and will help them to positively foster acceptance. Amaka Onu explains that

> Poor knowledge about the causes and nature of depression and other mental illnesses is common in our community and 'negative attitudes,' are widespread in the culture which impairs social integration in our community for those suffering from depression.

Chinyere Ono explains that education plays a vital role in understanding depression,

> ...education plays the greatest role because if the women receive education on the disease process and the various medications that are used for treatment, the women will go for the treatment, providing education to this community will detach the ancestral taboo and stigma that is attached to depression.

Uju Aku explains her experience with depressive symptoms, related how she felt alone and was not able to discuss her problems with others for fear of stigma and rejection. She describes her situation as being like in a hole:

> When I was suffering from depression, I was in this hole all by myself and people pass around you without helping you get out ... uh... but if you can come out of that hole, you would find you are not alone. Providing education for our community will help you share your story with other people, and you will find out that by just sharing your story with someone else helps you overcome the problem.

Summary of the Findings

The purpose of this qualitative study was to explore the meaning of depression from the Nigerian-born woman's standpoint. Through a series of 19 interviews (4 pilot and 15 dissertation), and review of the narrative data, an overarching theme and three distinct patterns emerged. Interpretation of the

narrative data gave further insight to the Nigerian-born women's perception. Depression was consistently described by the participants in this study as "mental illness," or "craziness." The women were not able to differentiate depression from other types of severe mental illnesses like schizophrenia. All types of psychological problems were considered as mental illness. From the interviews and narratives, the pattern of depression was described as madness or craziness, associated with evil spirits or a curse from one's enemies, and may be in the form of witchcraft, voodoo, or incantation. The participants described any woman suffering from depression as somebody possessed by the evil spirits or demons. Through the participants' narratives, it was apparent that Nigerian-born women will never admit to depression for fear of stigma and rejection from their community. The women used denial and secrecy to mask depression, which allows them to maintain their societal roles and continue to be a part of the larger Nigerian community.

Fifteen participants expressed their experience with depressive symptoms, but did not seek professional treatment, for fear of being labeled by the U.S. health care system as "mentally ill." Rather, the participants stated they use physical symptoms such as, "head hurts," "aches and pain all over body," "pressure on my chest," and so forth, to describe their problem to primary care physicians. All the participants expressed how depressive symptoms can cause isolation and rejection in the community, and frequently results in marital or

relationship conflicts. The participants report their greatest fear was that of transference of depression to their children that may be carried from generation to generation. Cultural expectations are the driving force that prevents marriage into families with a history of depression. According to the participants' narratives, Nigerian families are concerned with maintaining integrity and social acceptance in the community. Maintaining social status is more vital to Nigerians than the individual and, because of fear of being ostracized, families would not identify with a family member with depression. Spirituality and religion were identified as the main sources of treatment. The participants discussed spiritual deliverance, prayers, and fasting as their first line of treatment and considered them preferable to utilizing health care professionals. Education was identified as the single most factor that would improve the women's acceptance of depressive illness and also help foster professional treatment.

CHAPTER V

SUMMARY OF THE STUDY

This qualitative study explored the perceptions of Nigerian-born immigrant women who live in the U.S. toward depression. Specifically, the purpose of this study was to explore how the Nigerian-born immigrant women perceive depression, the meaning of depression, and the methods used to treat depression.

Depression has been predicted to be the second most common cause of disability worldwide by the year 2020 (World Health Organization, 2000). The Harvard Medical School (2004) estimated that one out of eight women in the U.S. will have an episode of major depression at sometime in their lives. Researchers have found that women experience depression twice as often as men (Ritsner, Pontzovsky, Nechemki, & Modai, 2001; Tseng, 2003). In many cultures, women encounter more emotional difficulties in their lives than men do, including gender discrimination and social restrictions (Tseng, 2003). Immigrant women often experience cultural conflicts that may impact development of depressive symptoms. According to Warnock (2004) tensions between societal expectations from the country of origin and the financial social needs of the new country may cause depression. Das, Olfson, McCurtis, and Weissman (2006) suggested that African ethnicities are more likely to be under diagnosed and under treated for

depression. A review of literature by Das and colleagues (2006) proposed the major barriers to diagnosis and treatment of depression in African population were identified as stigma of diagnosis, clinical presentation of somatization, and difficulties with patient-physician relationship. Bhugra (2004) recognized that when individuals migrate, they do not leave their beliefs, or idioms of distress behind. The innate beliefs influence how the women express symptoms of depression and their help-seeking behavior.

This chapter provides a summary of the current study and discussion of the study's findings in relation to other studies found in the literature. From the findings of this study, conclusions are stated as well as implications for nurses and other health care professionals who work with the immigrant women population. The chapter concludes with recommendations for educational programs aimed at demystifying mental health in this group.

Summary

Using Husserllian philosophy (Husserl, 1962, 1970) the researcher sought to learn, through the narratives of Nigerian-born women, their meaning and perceptions of depression. Data were examined using a phenomenological approach via semi-structured in-depth interviews with 19 Nigerian-born immigrant women. Following the method outlined by Colaizzi (1978), an overarching theme with three patterns that spanned six themes and 18 sub-themes were identified.

Nigerian-born immigrant women discussed their overall meaning and perceptions of depression that included three patterns: incurable and untreatable, stigma, and cultural influence. Incurable and untreatable was directed to depression as craziness and madness curse and spirit possession. The second pattern that emerged under the process of masking illness to retain social status in the Nigerian community was stigma. The stigma included denial and secrecy, isolation and rejection. The behavioral changes expressed by the women are somebody running around naked and not conforming to the norms of the community. The women described "chaining the women on both legs to prevent her from running out of the compound to the market square." The women explained that "nobody would like to identify with a mad woman." The third pattern is the cultural influence of "being strong" that prevent them from being depressed. Cultural influence includes spirituality, religion, and education. Prayers and fasting are used by the women to treat or prevent depression and there is a shift in attitude because all the women recommended a need for education about mental illness in the Nigerian community.

Discussion of the Findings

Husserl (1962, 1970) believed that experience as perceived by human consciousness has value and that subjective information ought to be important to scientists seeking to understand human motivation as human actions are influenced by what people perceive to be real (Lopez & Willis, 2004). The

findings from this qualitative study shed light on Nigerian-born immigrant women's meaning and perceptions of depression. In this study, participants perceived depression as something that can be controlled through their faith and depression is associated with negative connotations like a curse, and/or evil spirits. Nigerian-born women do not perceive depression as a medical problem, but as a personal weakness that can be overcome by a strong will. According to the participants, depression is said to affect people that are weak and it is the stronger person who turns to God to keep the depression out. These findings support the study conducted by Mills, Alea, and Cheong (2004) where African adults perceived depression as a personal weakness.

The theme craziness and madness support Nigerian-born women's belief that depression is "something bad affecting the brain." Participants' descriptions of depression included abnormal behaviors such as "running around naked," "fighting others unprovoked," and being "consistently angry." Other studies on the mental health of African people support these findings (Baker, 1994; Barbee, 1994; Bulus, 1996; Center for Addiction and Mental Health, 1999; Fontenot, 1993; Madu, 1996, Schrieber et al., 1998). These findings demonstrate that conceptualizations of mental illness stem from peoples' own understandings and interpretations of specific symptoms, the behavior of persons who are affected, and how those symptoms are uniquely experienced and explained in a particular society or culture (Akighir, 1982).

Many of the Nigerian-born women viewed depression as "something bad," which is reflected in the theme, curse, or spirit possession. According to the women, depression is caused by enemies of their grandparents or forefathers and/or by an action of their forefathers that did not sit right with their gods. The women explained that, "in those days, they have their gods and if they did not appease their gods, then it would be a curse on that family". This finding is supported by a study that found beliefs in the existence and activities of witches, ancestral spirits, sorcerers, and diviners still hold in traditional African communities (Aina, 2004). Other studies supported supernatural beliefs as causes of mental illness (Adebowale & Ogunlesi, 1999; Adewuya & Makanjuola, 2008; Akighir, 1982; Makanjuola, Adelekan & Morakinye, 2000; Odejide, Morakinya, Oshiname, & Omigbodum, 2002). It is strongly believed that an individual's wellbeing can be influenced through subtle manipulation of these agents that constitute the person's psychosocial environment.

Johnson (1982) stated that from prehistoric times until the middle ages, the most popular explanation of the cause of emotional disorders was demonic influence or being possessed by evil spirits. It was believed that a mentally disturbed person was in such condition because the person is possessed by evil spirits, and punished by the gods, or rendered mad by the spell of a witch doctor (Forrest, 1978). Johnson (1982) suggested that at the beginning of the Christian era, it was popularly believed that insanity was due to supernatural agents

personified by particular deities. Other studies supported that mental disorder result from demonic influence (Abiodun et al., 2008; Aina, 2004; Kabir et al., 2004, Quinn, 2007) and found that many African people on the continent perceive mental illness as being caused by external forces, such as evil spirits or deities, who utilized punishment for wrongful deeds. The Center for Addiction and Mental Health's study (1999) of the Caribbean community of Toronto findings suggest that the common beliefs for mental health problems were associated with: (a) depression that is brought on by a spell or evil spirit; (b) a punishment for wrongful deeds; (c) the person affected is considered as "crazy," "dangerous," or "weak" in character; and (d) hereditary factors.

Fontenot's (1993, p. 42) study found that community members in a rural southwest Louisiana Parish perceived "mental illness" as being the result of both "natural" and "unnatural" causes. A natural cause occurs as a form of punishment against someone who has sinned or wronged another individual by lying, stealing, committing incest, or other malevolent acts. In these circumstances, the Christian belief dictates that God punishes those who commit such acts. Those malevolent acts committed against another to cause physical harm or misfortune, is considered the unnatural causes of mental illness defined as voodoo, which is a curse that results in psychological illness (Fontenot, 1993). Kibir et al. (2004) found in their study that respondents believed that the cause of mental illness

includes drug abuse (34.3%), the divine wrath and God's will (19%), and beliefs in demons, magical or evil spirit possession (18%).

The theme denial and secrecy support Nigerian-born women's belief that depression is not an illness. One participant stated, "I have never heard about depression before, you are not suppose to be depressed, you are suppose to be a wife, a mother and someone to be looked unto for strength and there is no time for you to get depress." The participants on the other hand, mentioned diabetes and cancer as illness because one cannot control this illness, and reinforcing their beliefs that depression is not an illness, but a weakness. The findings point to the need for depression education for this population (Abiodun et al., 2008, 1991; Akighir, 1982; Gureje et al., 2005; Odejide et al., 2002; Makanjuola, et al., 2002). It was very common for the majority of the participants to describe depression as affecting someone else and not the participant.

The theme Isolation and rejection in this study was supported by one participant who stated, "I don't allow myself to be depressed," and "there is nothing call depression." The theme isolation and rejection is supported by Thompson, Bazile, and Akbar (2004) study. These researchers used focus groups to conduct the study, and the participants described mental illness as a shame and an embarrassment. Since emotional illness is viewed as an embarrassment in the Nigerian culture, Nigerian-born women may present with somatic complaints and increased physical impairment than emotional

complaints (Sellers et al., 2006). Primary care physicians may misidentify symptoms of depression if they are not presented as mood alterations (Snowden, 2001). These findings have implications for health care professionals working in the Nigerian community, who may benefit from additional training regarding the stigma associated with depression and approaches like screening methods to identify depression in this population. For example, inquiries about life events and losses, through the use of reminiscence may facilitate the development of trusting relationship and foster a therapeutic discussion about feelings of depression (Shellman, 2004; Shellman, Moody, Smith, Hewitt, & Martin, 2005). Additionally, framing questions within an appropriate cultural framework and in terms of somatic complaints may help identify symptoms of depression in this population.

Several studies identified that training health care workers on the etiology of mental illness improved their knowledge, perception, and ability to manage the mentally ill person (Adebowale & Ogunlesi 1999; Adewuye & Makanjuola, 2005; Adewuya & Oguntale, 2007; Makanjuola, Adelekan & Morakinyo, 2000; Odejide et al., 2002). The limited education about mental disorders in the Nigerian community, and the lack of understanding in this group increase the many other negative ideas about causes of emotional problems. Das, Olfson, McCurtis and Weissman (2006) stated more misunderstandings in Africans (15%) when

compared to whites (9%) regarding using physical symptoms to express mental health problems.

The theme, spirituality and religion, suggests the importance of religion and faith healing in the participants. Mental problems have been associated with demonism since Biblical times as evidenced in the New Testament, where Jesus cast out evil spirits from many who were possessed with demons (St. Matthew 8:16). In addition, the gospel narratives relate specific instances in which Jesus cast out evil spirits including the cases of the demon possessed man of Gadara. Several authors (Aina, 2004; Jegede, 2005; Kabir et al., 2004; Kamya, 1997; Quinn, 2007; Yoho & Ezeobele, 2004) identified religion as help-seeking behaviors that are used by the Africans, Caribbeans, and other immigrant women. Religion and faith healing ranked as the number one intervention Africans and Caribbean women used to cure or prevent depression. These authors posit that spirituality and religion are crucial in helping the women cope with mental health problems. The belief in a higher power for dealing with life's hardships has long been an important source of strength for African people living outside their homeland (Kamya, 1997). Other findings indicated that religiosity was associated with well-being in Africans and serves as a protective factor to prevent depression (Chiriboga, & Mortimer, 2005; Cummings, Neff, & Husaini, 2003; Jang, Borenstein, Taylor, Chatters, & Levin, 2004).

Participants in this current study stated that turning to God would assist them in maintaining control over adversities and that their faith was an important part of their coping mechanisms. Pak (2006) identified that churches have been a potential contributor to immigrant mental health as they tend to reinforce traditional roles and values. A negative side to this belief may warrant further discussion. During interviews for example, some of the participants were tearful as they spoke; on the other hand, they verbalized, "I'm not depressed, and God will prevent me from getting depression." The participants' tearfulness and sadness did not correspond with what was said during the interview. This example represents evidence that Nigerian-born women with strong religious beliefs minimize mental health problems and do not seek treatment or admit to feeling depressed. Although the relationship between religiosity and mental health in Nigerian-born women is complex, assessing the women's beliefs can assist in the identification and support for mental health promotion.

Conclusions and Implications

This study highlights the impact of culture on how Nigerian-born immigrant women understand depression regardless of the length of stay in the U.S. The reliance on traditional belief systems has resulted in the adoption of more traditional explanations of depression. The women's explanation of depression is culturally specific. From the study findings, the participants have a greater belief that spiritual factors are responsible for depression. Even though the general

knowledge about the nature of mental illness is uniformly poor in this population, there was no difference in the awareness of depression between those Nigerian-born women who have lived in the U.S. from 5 to 31 years and the unpublished pilot study results with women participants who had lived in the U.S. for five and less years. The findings from this study have important ramifications for the assessment of risk and delivery of mental health services to this population. It is important to note that the findings from this study indicate, no matter the number of years the participants spent in the U.S., the women still retained their cultural beliefs.

This study results show some challenges for mental health professionals in working with Nigerian-born women. In order to gain these women's trust, the health care professional must first of all establish a safe trusting relationship and make the women feel valued and understood within their cultural context. Qualitative study with the Nigerian-born immigrant women serves as the beginning phase to understanding this population, and professionals can then humbly begin to help this group and unravel the mystery and perception of depression. Researcher must understand that somatic complaints may serve as similar idioms of distress in different cultural groups, and that culture shapes the expression of distress in this population (Ehigbo, 1982). Cultural factors could also lead to disproportionate denial of psychiatric symptoms (Abiodun et al., 2000; Jegede, 2005; Sellers et al., 2006).

These findings are important for mental health professionals. Preventing the decline of mental health services among this population and other immigrant women groups should be an important priority. In addition, these findings suggest important questions for future research that could improve public health. Understanding the factors that contribute to mental health causes of immigrants could provide clues to preventing the perception of depression in this population and other immigrant women populations. There is evidence of ethnic differences in the conceptualization and attributions of depression. Practitioners must seek to understand Nigerian-born immigrant women's understanding and explanations of depression to gain insight about ways to build an effective treatment agreement and educational programs with this group and other health care professionals.

Recommendations for Further Studies

This study demonstrates the need for educational programs aimed at demystifying mental health problems in this population. A better understanding of depression among Nigerian-born immigrant women would allay fear and mistrust about mentally ill persons in the community, as well as lessen stigmatization towards such persons. The study presents a picture of depression that has important implications for health care professionals. Findings suggest the need for additional qualitative research that considers the heterogeneity of experience within the Nigerian population. There is a need for further study or studies with various populations and more diverse samples. The present sample had

important sampling limitation, not a study limitation, which does limit generalization. The sampling methodology used was purposive in that certain criteria were chosen for the group to be studied (Denzin & Lincoln, 2000). The study selection criteria require that all participants must have emigrated directly from Nigeria to the U.S. Other sample restrictions were that the participants were Nigerian-born women recruited from one city in a southwestern U.S. state and not throughout the U.S., and not all Nigerian ethnic groups were represented in the study

Future research might focus on Nigerian born women from other ethnic groups, and living in other parts of the U.S. and would allow for exploration of diversity within Nigerian-born immigrant population. From a research standpoint, researchers tend to treat all blacks in the U.S., including Nigerians, as the same. Including Nigerians with other blacks is not an effective way of studying Nigerians because the cultural beliefs are often ignored and not taken into consideration. Future studies on blacks should use specific ethnicity in order to generalize results to that particular group. Cultural and language specific education in the Nigerian-born immigrant population could be directed to modifying their attitudes and understanding of depression, and not only to reduce stigma, but also to enable self-identification of depression.

Conclusion

Kierkeguard, a 19th century philosopher, stated that if we want to help human beings, we must start where that person is (Garff, 2005). It is not possible to deliver meaningful care to Nigerian-born women unless health care professionals are receptive to their unique perception of depression (Schreiber, Stern & Wilson, 2000). The findings of this study indicate the importance of in-depth analysis of culturally specific definitions of depression. The work of promoting health and preventing diseases has to be built around perceptions and knowledge of the women themselves, and the strategies they use to attain well-being (Wilkinson & Pierce, 1997).

Through narrative descriptions, participants in this study have shared their experiences and perceptions with the researcher. This contribution to nursing and health care professionals' knowledge will strengthen our understanding of the meaning of depression through Nigerian-born immigrant women's cultural lens. The participants' willingness to discuss their perception toward depression demonstrates a positive start for this population and may help other immigrant women who are ashamed to speak out due to the stigma attached to depression in their culture. It is important that mental health professionals become mindful and sensitive to cultural and linguistic patterns in understanding Nigerian-born immigrant women's perceptions and their expression of depression (Park & Bernstein, 2008).

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APPENDIX A

Depression Studies in Nigerians and Immigrant Women

Depression Studies in Nigerians and Immigrant Women

Author (Year)	Sample & Setting	Methods	Findings
Abiodun (1991)	N = 207primary health care (PHC) workers in University of Ilorin, Nigeria.	Using a structured questionnaire, 207 PHC workers were assessed on the concept, attitude to, detection and treatment of mental disorders.	PHC workers without previous exposure to mental health training were significantly more likely to hold on to traditional views on the etiology of mental disorders. Many of the PHC workers expressed a general negative attitude towards mentally ill patients.
Abiodun et al. (2008)	N= 2,078 respondents from south western Nigeria	A cross-sectional survey in which respondents were administered questionnaire detailing socio-demographic variables and perceived causation of mental illness. The study evaluated patterns and correlates lay beliefs regarding causes of mental illness in southwestern Nigeria	Beliefs in supernatural factors were most prevalent. Urban dwelling, higher educational status, and familiarity with mental illness correlated with a belief in biological and psycho-social causation, whereas, old age, rural dwelling, and lack of familiarity correlated with a belief in supernatural causation. Educational status was found to have an effect on the belief in supernatural causation.
Adewuya and Makanjuola (2005).	N= 1668 students of a Nigerian Federal University	A modified version of Bogardus Social Distance scale was used to assess the desire for social distance towards people with mental illness among students in a Nigerian University. Socio-demographic data was also obtained	Social distances increased with the level of intimacy required in the relationship, and were higher than those from the Western culture, with 65.1% of respondents categorized as having high social distance towards the mentally ill people. Social distance towards the mentally ill is higher amongst Nigerian University students than expected.

Adebowale and Ogunlesi (1999)	N= 140 (70 out-patients with psychotic disorders and 70 accompanying relatives. Setting was Neuropsychiatric Hospital, Aro-Abeokuta, Nigeria.	A set of in-depth interview questions about their beliefs concerning the cause of the illness, and their awareness of other possible etiological factors. Relevant socio-demographic and clinical information were elicited.	The most acceptable etiological causes were supernatural for both patients and relatives. Psychosocial stressors were the least acceptable cause of mental illness.
Adewuya & Oguntade (2007)	N=312 medical doctors from eight selected Health Institutions in Nigeria	A set of questionnaires on knowledge and attitude towards people with mental illness	Beliefs in supernatural causes were prevalent and the mentally ill were perceived as dangerous and their prognosis perceived as poor. High social distance was found among 64.1% and the associated factors include not having a family member/friend with mental illness. Culturally enshrined beliefs about mental illness were prevalent among Nigerian doctors. The study concluded a review of medical curriculum is needed and the present anti-stigma campaigns should start with the doctors.

Aina (2004)	N=163 films produced in West Africa	Examination of portrayal of West African films. 25 contain scenes of psychiatric illness	The causative factors of these "illnesses" were largely attributed to supernatural or preternatural forces. The effective treatment or "healing" of the illnesses was portrayed as arising mostly through magical means or traditional forms of care. In addition, sudden death from "spiritual attack" by these agents was shown. Scenes of witches and occultists wreaking other forms of havoc on victims at night were shown in eight of the films. The film portrayals of psychiatry and supernatural forces for the public and for orthodox psychiatric practice in the region were highlighted.
Akighir (1982)	N= 80 Nigerians living in Plateau State, Nigeria	Investigation of traditional and modern psychiatry using survey to obtain information on the opinions and beliefs amongst people in Plateau State, in terms of sex, educational level, and locality (rural and urban)	Attitudes toward traditional healers were favorable, that mystical causes of "madness" are the most accepted, and that traditional healers are felt to have important role to play in treating "mad" people. These findings apply regardless of educational level or locality.
Beyero et al. (2004)	N=1,854 men and women (1,067 were females) in Southern Ethiopia	To estimate the prevalence of psychiatric disorders and their socio-demographic correlates among the Borana semi-nomadic community in southern Ethiopia. A cross-sectional survey was conducted in three areas of the Borana zone.	The lifetime prevalence of all psychiatric disorders, including substance abuse, was 21.6%. That of mental disorder excluding substance abuse was 14.6%. The prevalence of neurotic and somatoform disorders was strongly associated with female sex.

Bhugra (2003)	Published data	Used published data to review the theoretical background for migration and to study the existing literature on rates of depression in various migrant and ethnic groups.	Findings indicated that the rates of depressive neurosis vary according to migrant status. Migrants in some groups are less likely to report symptoms of depression and acculturated individuals are more likely to be depressed.
Ebigbo (1982)	N= 528 (179 psychiatric patients and 349 students of the Institute of Management and Technology IMT) in Enugu, Nigeria	A questionnaire was administered to psychiatric patients and the same questionnaire was administered to IMT students. 65 somatic complaints of psychiatric patients treated by three psychiatrists and clinical psychologist from 1978-1981 were collected and arranged in form of a questionnaire. Twenty-three of these items referred to the head, while 42 referred to the body. The purpose of this study was to find out how the somatic complaints differ from these two groups-psychiatric patients and IMT students.	The findings show that the psychiatric patients as well as the IMT students used somatic complaints when describing symptoms of illness. The result led the researcher to doubt reliability in the use of the Western Diagnostic Illness Categories for labeling mental illness in Nigeria
Gureje et al. (2005)	N= 2,040 males and females Three Yorubs speaking states in southwestern Nigeria (Ogun, Osun, and Oyo)	Survey was conducted examining the relationships between views about causation and attitudes to mental illness	Poor knowledge of causation was common. Negative views of mental illness were widespread, held by as many as 96.5%. Most would not tolerate even basic social contact with a mentally ill person. 82.7% would be afraid to have conversation with a mentally ill person. Only 16.9% would consider marrying someone with mental illness.

Jegede (2005)	N = 10. Purposive sample. Five traditional healers and five diviners (three women and seven men)	In-depth interviews to examine the Yoruba concept of mental illness and their help-seeking behavior. The study was conducted in Ibadan, Nigeria, a Yoruba community. Data was collected from ten key informants who were traditional healers.	Findings of the study indicated that Yoruba ethnic group does not believe that mental illness can be permanently cured, because a mentally ill person is being controlled by spirits. The diviners in the study believed that mental illness resulting from a spiritual attack can only be cured spiritually, and to know the type of spiritual therapy to apply, the diviner has to divine in order to confirm. Once the appropriate rituals are performed, the person would maintain stable mental health and the problem can only relapse if the person violates the taboos of the gods again. The traditional healers believed in the role of gods and that physical materials are efficacious in the treatment of mental illness.
Kabir et al. (2004)	N= 250 (Males 167 and Females 83) residing in Karfi village, about 15 kilometer from Kano city, Nigeria.	A cross sectional descriptive study. Modified a pre-existing semi-structured questionnaire to evaluate the perceptions and beliefs of adult in Karfi village.	Findings of the study indicated that respondents believed that the major cause of mental illness included: drug misuse 34.3%, followed by divine wrath or God's will 19%, and magic or spirit possession 18%.
Kamya (1997)	N=52 African immigrants in U.S.	Survey questionnaire measuring coping, self-esteem, hardiness, spiritual wellbeing	Spiritual well-being was significantly related to lower stress levels and greater hardiness and self-esteem and overall coping

Makanjuola et al. (2000)	N= 43 (twenty-seven traditional mental health practitioners (TMHPs) and 16 patients' relatives, in Ilorin Emirate Council area, Kwara State, Nigeria.	Data was collected using Practitioners' questionnaire (PQ) and Patients' Relatives Questionnaire (PRQ), use of focus group discussions and observations of TMHPs in their clinics. Factors which affect utilization of traditional mental health services were reviewed	About 74% of TMHPs expressed interest in attending seminars aimed at improving their skills, while most patients' relatives expressed the belief that only traditional healers can understand the supernatural etiological basis of mental disorders and can therefore offer effective care than orthodox mental health practitioner
Miranda, et al (2005)	N= 5,122 Latina immigrants in USA The women were screened for major depression while they were at the service setting	Screening was used to recruit prospective participants for the Women Entering Care (WE Care) study by three Institutions-Georgetown University, the State of Maryland and the University of California.	Overall, 11.7% of the sample screened positive for major depression. The rates of depression were 11.4% for women who lived with their children, 10.9% for those who do not have children, and 18.1% for those who were not living with their children. When the analyses was controlled for demographic differences, the odds of depression for immigrant Latinas who were separated from their children were 1.52 times as great as the odds for those whose children are currently living with them.

Miller & Chandler (2002)	N = 200 women age 45-65 years from former Soviet Union who lived in the U.S. fewer than six years	Data for analysis was from Migration and Health Project, a cross-sectional study that explored the impact of immigration and resettlement during midlife on women's health. Self-administered questionnaires were administered under the supervision of a research staff. Completion of questionnaires took two to three hours. Symptoms of depression was measured using English Proficiency, Demands of Immigration scale test and CES-D scale	The findings include very high scores on the depression scale CES-D compared to U.S. norms. Older women, and those reporting greater demands of immigration, had higher scores on the depression scale. Lower depression scores were found for women reporting greater English usage.
Noh & Kasper (2003)	N = 188 Korean immigrant parents residing in Toronto, Canada completed Korean version of CES-D	Cross-sectional data derived from personal interviews examined how racism/ethnic discrimination may be related to depression. The authors focused on the ways in which individuals respond to perceived discrimination and how personal coping responses, as well as acculturation and ethnic social support, moderate the impact of perceived racial stigma on depressive symptoms. Health consequences of depression vary according to personal coping responses.	Findings indicated that perceived discrimination and emotional reactions exhibited significant direct associations with depression as measured with the CES-D-K

Odejide et al. (2002)	N= 62 primary health care workers in University hospital Ibadan, Nigeria.	Training needs of Primary Health care workers were assessed through focus group discussions and structured self-administered questionnaire, A two-day training program on the recognition and management of depression was conducted using an adaptive version of the World Psychiatric Association (WPA) guidelines for management of depression in primary health care.	Pre-training, the health care workers had very poor knowledge of depression. There was significant improvements in knowledge post training The training increased PHC workers knowledge about the concept, recognition, and management of depression.
Quinn (2007)	N= 80 family caregivers across four sites in Ghana	Semi-structured interviews used to explore the impact of different cultural beliefs on society's beliefs on mental illness.	There appears to be greater reliance on culturally specific explanations of mental illness. Respondents saw spiritual factors such as curse or bad spirits, as being more significant in the causation of mental illness. Findings suggest that in urban Ghana, there was greater belief in biomedical explanation of mental illness, whereas in rural areas, people were most likely to believe in spiritual factors as responsible.

Salgado de Snyder (1987)	N=140 Mexican-born immigrant women, ages 19-49, married for the first time in Los Angeles	A telephone survey was used for data collection, designed in Spanish. The questionnaire measured circumstances of the immigration experience, loyalty towards Mexican culture, self-esteem, depressive symptomatology, general satisfaction, and demographic information. Depressive symptomatology was measured with Spanish version of the Center for Epidemiology Studies Depression Scale (CES-D)	A very strong and significant correlation between acculturation stress and depressive symptomatology was observed. Furthermore, acculturation stress by itself significantly predicted 16% of the variance in depressive symptomatology.
Schreiber et al. (2000)	N=12 Black West-Indian Canadian women who experienced depression	Exploratory grounded theory	The women in the study managed their depression in a culturally defined way, by being strong and not showing vulnerability

Sellers, Ward and Pate (2006)	N=13 African families	Exploratory focus group addressing health and wellbeing Thirteen families were recruited through two major African associations in the U.S. Each participant received a cash gift of 20 dollars. Focus groups were facilitated by two doctoral students, one master's level student, and two undergraduate students. These students received training in group facilitation and research procedures. A brief demographic questionnaire was used to obtain background information.	The results of study indicated that the women were concerned about depression. The women shared their beliefs about the causes of depression. Depression was perceived as madness. The words participants used to describe symptoms of depression appeared to be more psychosomatic in nature, like body aches, physical tiredness and headaches. The contextual factors of depression as suggested by participants were associated with seven factors: change, parenting responsibilities, gender role strain, difficulties with systems, financial concerns, racism, and social isolation. The participants used culture-bound coping such as silence to cope with depression (Sellers et al., 2006).
Taylor, Chatters & Jackson (2007)	N =16 measures of organizational, non-organizational of older Black Caribbean subsample	National survey of American Life were used to examine selected measures (16) of organizational, non-organizational, and subjective religious participation	The findings indicated Caribbean blacks reported higher levels of religious participation.

Waldron (2002)	N=10 (6 African Canadian women and four mental health professionals.	In-depth interview was used with each informant that lasted one hour and thirty minutes. It examined how the various conceptualizations African Canadian women hold about "mental illnesses" influence their propensity to seek out particular forms of treatment methods.	African Canadian women often heal their mental health problems by combining the more traditional practices that are indigenous in their cultures with Western psychiatric approach The women's age, socio-economic status, educational level' language, culture and beliefs about psychiatry, and "mental illness" causation greatly influences the types of help-seeking that African Canadian women engage. These women are least likely to attend psychotherapy and psychiatric counseling, mainly because of shame and stigma that is still associated with these approaches within the African and Caribbean communities. The women have tendency to speak more with their bodies than their emotions when they express symptoms of "mental illness"
Yoho & Ezeobele (2002)	N=19 Hispanic women age 61-82 in a senior citizen center in Harris County, Texas, USA.	Semi-structured interview questions to explore the Hispanic women meaning of health	The findings to the study indicated that the women believed that having faith and belief in God help them maintain their overall health, including mental health.

APPENDIX B

Recruitment Flyer

A Research Study Conducted by Texas Woman's University

Doctoral Nursing Student

Depression and Nigerian-Born Immigrant Women in the United States: A Phenomenological Study

Seeking to recruit Nigerian-Born Immigrant Women to Participate in a Research Study on Mental Illness

Criteria for Participation:

Women ages 18 and older

Living in the U.S.

Immigrated directly from Nigeria to the U.S.

Contact Information:

If interested, please contact Ms. Ify Ezeobele

APPENDIX C

Approval Letter from Institutional Review Board

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Office of Research
6700 Fannin Street
Houston, TX 77030-2343
713-794-2480 Fax 713-794-2488

June 12, 2008

Ms. Ifeoma Ezeobele
College of Nursing - Ann Malecha Faculty Advisor
6700 Fannin Street
Houston, TX 77030

Dear Ms. Ezeobele:

Re: "Depression and Nigerian-Born Immigrant Women in the United States: A Phenomenological Study"

Your application to the IRB has been reviewed and approved.

This approval lasts for one (1) year. The study may not continue after the approval period without additional IRB review and approval for continuation. It is your responsibility to assure that this study is not conducted beyond the expiration date.

Any changes in the study or informed consent procedure must receive review and approval prior to implementation unless the change is necessary for the safety of subjects. In addition, you must inform the IRB of adverse events encountered during the study or of any new and significant information that may impact a research participant's safety or willingness to continue in your study.

Remember to provide copies of the signed informed consent to the Office of Research, IHS 10110 when the study has been completed. Include a letter providing the name(s) of the researcher(s), the faculty advisor, and the title of the study. Graduation may be blocked unless consents are returned.

Sincerely,

John D. Radcliffe

Dr. John Radcliffe, Chair
Institutional Review Board - Houston

APPENDIX D

Consent to Participate in Research

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Nelda C. Stark College of Nursing
Houston Center
6700 Fannin Street, Houston, TX 77030-2343
713-794-2100 Fax 713-794-2103

Pioneering Nursing's Future:
An Adventure in Excellence

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: Depression and Nigerian-Born Immigrant Women in the United States: A Phenomenological Study

Investigator: Ifeoma Ezeobele, ----------832-630-2282
Advisor: Ann Malecha, Ph.D.----------713-794-2725

Explanation and Purpose of the Research

You are being asked to participate in a research study for Ms. Ifeoma Ezeobele's dissertation at Texas Woman's University. The purpose of this research is to describe the experiences of Nigerian-born immigrant women living in the US related to their perceptions of depression. Your participation in the study will provide insight on how the women describe and define depression and their experiences with depression.

Research Procedures

Agreement to participate in this study indicates your willingness to complete a form about you age, place of birth, education, relationship status, and other similar personal information. The investigator will conduct face–to-face individual interviews with you that may last between 60 to 120 minutes. A follow-up interview may be required and this will last no more than 30 minutes. The interviews will be conducted in a private office or home on a date and time convenient to you. The face-to-face interview will be tape recorded with two digital recorders to ensure accuracy of information obtained during the interview. Your maximum total commitment in the study is estimated to be up to 2 ½ hours. You will receive $20.00 cash for participating in this study.

Potential Risks

Potential risks related to your participation in the study are minimal, and include fatigue and physical or emotional discomfort during your interview. To avoid fatigue, you may take a break (or breaks) during the interview as needed. If you experience physical or emotional discomfort regarding the interview questions, you may stop answering any of the questions at any time. You will be referred to follow-up with your own personal health care provider for ongoing discomfort.

Another possible risk to you as a result of your participation in this study is release of confidential information. Confidentiality will be protected to the extent that is allowed by law. The interview will take place in a private location agreed upon by you and the researcher. A code name, rather than your real name, will be used on the demographic sheet, audiotapes/digital voice recorder and the transcription documents. Only the investigator and transcriptionist will have access to the tapes.

Participant Initials

Title: Depression and Nigerian-born immigrant Women in the United States: A Phenomenological Study

The tapes, hard copies of transcriptions, and the computer diskettes containing the transcription text files will be stored in a locked filing cabinet in the investigator's office. Only the investigator, committee, and transcriptionist will have access to the transcriptions. The tapes and transcription diskettes will be erased and the hard copies of the transcriptions will be shredded within 5 years after completion of the study. It is anticipated that the results of this study will be published in the investigator's dissertation as well as in other research publications. However, no names or other identifying information will be included in any publication.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this research study is completely voluntary, and you may discontinue your participation in the study at any time without penalty. The only direct benefit of this study to you is that at the completion of the study a summary of the results will be mailed to you upon request.*

Questions Regarding the Study

If you have any questions about the research study you may ask the researchers; their phone numbers are at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research at 713-794-2840 or via e-mail at IRB@twu.edu. You will be given a copy of this signed and dated consent form to keep.

_____ _____

Signature of Participant Date

The above consent form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge of its contents.

_____ _____

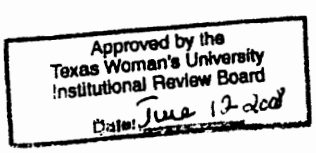
Signature of Investigator

Date

* If you would like to receive a summary of the results of this study, please provide an address to which this summary should be sent:

_____

_____



APPENDIX E

Consent to Record

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Nelda C. Stark College of Nursing
Houston Center
6700 Fannin Street, Houston, TX 77030-2343
713-794-2100 Fax 713-794-2103

Pioneering Nursing's Future:
An Adventure in Excellence

CONSENT TO RECORD
Texas Woman's University

"Depression and Nigerian-Born Immigrant Women in the United States: A Phenomenological Study"

You consent to have your voice recorded by Ifeoma Ezeobele acting on this date under the authority of the Texas Woman's University with the understanding that the material recorded today may be made available for research purposes, and you consent to such use.

_____ _____
Participant Date

***

The above consent form was read, discussed, and signed, and you sign this consent form freely and with full knowledge and understanding of its contents.

_____ _____
Representative of the Texas Woman's University Date

APPENDIX F

Demographic Data Form

Demographic Data Form

Code: _____

1. Age _____(years)

2. Place of birth in Nigeria: _____

3. Dialect(s) spoken: _____

4. Year immigrated to the U.S.: _____

5. Have you lived in any country other than the United States? (circle one) YES NO

6. If yes, name of country? _____

7. Highest level of education _____(# of years)

8. Relationship status (circle one):
   a. Not in a committed relationship
   b. In a committed relationship
   c. Married
   d. Divorced
   e. Widowed
   f. Other_____

9. Do you have children? (circle one) YES NO

10. If yes, number of children: _____

11. Age of children listed above: _____

12. Occupation in Nigeria? _____

13. Occupation in the U.S.? _____

14. Are you employed outside the home? (circle one) Full-Time Part-time Unemployed

15. Have you ever been diagnosed with depression? (circle one) YES NO

16. If yes, what month/year? _____

17. What type of health care provider diagnosed the depression? _____

18. Did you receive or are you currently receiving any type of treatment for depression? (circle one) YES NO

19. Do you have any relatives who live in the U.S.? (circle one) YES NO

20. If yes, the state and city? _____

21. What do you do for leisure? _____

APPENDIX G

Interview Questions

Interview Questions

Depression and Nigerian-born Immigrant Women in the United States: A Phenomenological Study

1 When you hear the term depression, what does that mean to you?

2 When you were growing up in Nigeria, what attitude did you have towards depression?

3 When Nigerian-born women in the U.S. seek help for depression, who do they go to for such help?

Probes:

a. What will prevent the Nigerian-born women in the U.S. from seeking treatment for depression?

b. What will help the Nigerian-born women seek treatment?

4 What are your personal experiences of depression?

Probes:

a. What helps?

b. What makes it harder?

5 When you think of depression experiences, what are the differing beliefs held in the U.S., from those held in Nigeria?

APPENDIX H

Significant Statements from Transcripts

Significant Statements from Transcripts

1. Usually when they say "depression", somebody's depressed or something, usually they like somebody crazy, somebody having problems with the brain or something.
2. I even experienced somebody from my area, when the person is coming with a little rag closing the private part and all of us will be running.
3. It has never been accepted as something that need to be treatable
4. Usually, there is this belief that when someone is mentally having problems or breakdown.
5. Depression goes to the head and causes scatterbrain
6. A person with any type of psychological problem is labeled madness
7. Witches and wizards are responsible for afflicting depression on a person through witchcraft
8. I have heard witches confess how they inflicted depression on a woman in my village
9. Nobody wants to reveal they have depression because they are afraid they will be considered mad
10. It is abomination and a taboo
11. It is something that does not worth discussing in our community, something like voodoo or something going on in the person's head.

12. The person's behavior is attributed to someone else did something bad to the individual
13. The person is looked as an outcast and probably has a curse placed on them and now the curse has manifested.
14. That person is isolated and their family and it is difficult for them to mix up with other normal people because we believe that they have a curse.
15. A curse from either their enemies, enemies of their grandparents, or something their forefathers did that was not right with their gods.
16. In those days they have their own gods and if they did not appease their gods, then it would be a curse on them.
17. When I hear the term depression, my understanding about depression is mental illness.
18. The person is looked at as weird person because they are running around naked and fighting others
19. Some will say the woman is possessed by water spirits, and demons
20. There is nothing called "depression" in Nigeria. A woman is not supposed to be depressed, we see it as part of life
21. Once a person deviates from what the community considers "normal", we generally say that something is wrong with the person "upstairs"

22. Depression means being in a state of confusion mentally, physically and socially.
23. Even in marriage, we do not marry from a family with a history of depression
24. This is a cultural requirements for all marriages
25. Depression is spiritual, therefore, you must go to the clergy for spiritual healing, through prayers, fasting, and pastoral counseling
26. You must depend on God to chase away the evil spirit
27. I have been in the U.S. for 26 years and I don't think I will go to the Doctor to seek treatment even if I am depressed because of cultural beliefs
28. Depression is caused by sins of our forefathers
29. Depression is 'ogbanje' back home where somebody living a dual life.
30. People feel shame to talk about their depression
31. There is nothing called depression
32. Depression is caused by spiritual attack or voodoo
33. A woman is not supposed to be depressed
34. A woman is supposed to be a role model for others to emulate
35. A woman does not have time to be depressed.
36. Depression is just like being in a hole where you are there alone and others are passing by, and nobody bothers to get you out of that hole

37. Nigerians do not believe in counseling, or going to seek help
38. Depression is a normal way of life
39. The woman will deny depression because it is belittling
40. Physical symptoms such as 'head hurts,' 'burning sensation all over body,' 'pressure on my chest,' 'aches and pains all over ,' are mostly used to express emotional problems
41. The woman with depression is just like an aggressive dog that prevents others from entering your house
42. Healthcare professionals will not keep your illness confidential
43. Nigerian-born women do not allow themselves to get depressed
44. The Bible study and prayers is a spiritual way to strengthen one's faith or the spirit that was weakened
45. Depression is a curse attributed by the enemies
46. If you are not working according to the demands of the gods, the gods will come against you and start fighting and inflicting you with depression
47. Depression is curable if the individual is religious
48. Christians rely on spiritual warfare to cast out this illness
49. Education in the Nigeria community in the U.S. is needed to dispel ancestral taboo and stigma attached to depression
50. The way we grew up never leaves us, your culture never leaves you

51. Education will help take away this satanic brainwashing
52. Revamp Nigerian culture by doing some editing, because there are things rooted in the culture that we need to let go
53. Nobody knows the difference between you are depressed or hallucinating like in schizophrenia
54. A person with depression is regarded as somebody possessed by water spirits, or demons
55. Depression was referred to as leprosy or aids
56. People suffering from depression should not be allowed to socialize with normal people
57. If you admit that you have depression, that will be the beginning of your downfall in the community
58. People do not want to feel that they are product of satanic incarnation
59. A lot of people believe that depression is transferable
60. There is fear of transference of depression to offspring
61. Stigma and taboo associated with depression often results in the woman masking their symptoms and focusing on physical symptoms
62. Depression is not considered a disease like diarrhea or cancer
63. You are supposed to be a mother, a wife, and there is no time for anybody to suffer depression

64. I don't think I can ever change my mind about depression because it is evil controlled

65. No matter how much education you have, we still abide by our cultural beliefs and our culture is still here in the U.S..

66. I will be skeptical to allow my child to marry from a family with history of depression

67. Any person who is mad is isolated in their room or at a corner in their compound with chains on both legs to prevent running outside to market place.

68. Depression becomes incurable once the person runs into the market square

69. We avoid any person with depression

70. The community labels any person who is behaving abnormally as "something wrong with the person upstairs."