

2018

THE IMPACT OF THE 2014-2016 EBOLA EPIDEMIC ON SIERRA LEONEAN IMMIGRANTS IN THE UNITED STATES

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THE IMPACT OF THE 2014-2016 EBOLA EPIDEMIC ON SIERRA LEONEAN
IMMIGRANTS IN THE UNITED STATES

BY

DAPHNE J. COLE

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN
PSYCHOLOGY

UNIVERSITY OF RHODE ISLAND

2018

DOCTOR OF PHILOSOPHY DISSERTATION

OF

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2018

ABSTRACT

The 2014-2016 Ebola epidemic represented the largest outbreak in the history of the disease and it took a tremendous toll on the West African countries of Guinea, Liberia, and Sierra Leone who were impacted by a disease that had never been seen in their part of the world. While the epidemic significantly impacted those three nations, reported cases also spread to African countries such as Mali, Nigeria, and Senegal, as well as countries in the western world, such as Spain and the U.S. prior to the West African epidemic. Ebola was perceived in the U.S. as a distant threat dramatized by the media and entertainment industries. However, the introduction of Ebola into the U.S. triggered intense national media attention and widespread public alarm. When the first case of Ebola was diagnosed in a man in Dallas, Texas, the public's resulting fear was disproportionate to the actual risk of transmission. As fear of exposure increased, stigma affected both returning aid workers and persons from Africa living in or visiting the U.S. The purpose of the present study was to qualitatively explore the experiences of Sierra Leonean immigrants living in the U.S., in order to describe their experiences with Ebola-related stigma and perceived risk for Ebola as part of their ongoing acculturation experiences. The sample comprised of 15 individuals who originally emigrated from Sierra Leone. Individual interviews were used and descriptive content and thematic analysis was utilized in order to guide data analysis. Results revealed that while Sierra Leoneans in the U.S. did experience Ebola-related stigma and heightened perceived risk for contracting the Ebola virus during the

epidemic of 2014-2016, it did not impact the participants' sense of belonging and ongoing adjustment in the U.S.

ACKNOWLEDGEMENTS

First I would like to acknowledge the overall support that I have received from my major professor, Paul Florin throughout my tenure in graduate school. From the very beginning he has been extremely patient, applauded every triumph, and offered continual encouragement through each challenge. I am forever grateful for his mentorship throughout this process. I am also grateful for the thoughtful input and integral feedback of my committee members, Ginette Ferszt and Margaret Rogers. Having your support over the years has challenged me and strengthened my knowledge and application of qualitative research methods. I am especially grateful for the help and support of Friends of Sierra Leone, Peggy Murrah, Aiah Fanday, Amadu Massally, Jim Sheahan, Krio Descendants Union, and Olive Hamilton, alongside all of the wonderful people who were interviewed and have allowed me to share a part of their life story. I would also like to acknowledge Ann Smith, Doylannie Walker, Malcolm Whittington, Kristen Joseph, Raven Williams, and Diasia Williams for all of their with help data analysis, their efforts really launched me into the final phase of this process.

I am also grateful for the ongoing support and encouragement of my parents Doreen Williams and Godfrey Cole who have not only instilled in me a great sense of pride about my Sierra Leonean and Jamaican heritage but have also encouraged me to reach for the stars, dream big, always trust God and work hard to actualize my potential. I am also very appreciative of my other family members, friends,

supervisors, and mentors who never ceased to provide me with the reassurance that I needed to keep pushing despite all obstacles. I would also like to acknowledge every Panera Bread, Starbucks, Brewed Awakenings, and Small Point Café that I have come across during my graduate studies because without those spaces to buckle down and focus, I would not have made it this far.

Most of all I would like to thank my Lord and Savior Jesus Christ for the guidance and perseverance throughout this research project and my graduate studies. Throughout my matriculation in this program, I have relied on my faith in God and His promises which state that “I can do all things Christ who strengthens me” (Philippians 4:13 New King James Version), and “For I know the plans I have for you declares the Lord, plans to prosper you and not to harm you, plans to give you hope and a future” (Jeremiah 29:11 New International Version). Resting on these promises has shown me that in times of uncertainty and challenge, spiritual strength and resolve can help one endure the journey. It is my hope that this project will lead to continued efforts to examine the underexplored realities of Sierra Leoneans in the U.S. and throughout the diaspora.

DEDICATION

This project is dedicated to my late grandmother Thelma Rose Cole who passed away on March 31, 2018. She always instilled in me the importance of trusting God and her favorite quote was “Good, better, best, never let it rest. Until your good is better and your better is best”. In her memory I will always strive to make my good even better and transform my better into my best. I would also like to acknowledge all of the lives that were lost during the West African Ebola epidemic of 2014-2016. May all your souls rest in perfect peace.

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CHAPTER 1

INTRODUCTION

The present study sought to explore how the 2014-2016 Ebola epidemic impacted West African immigrants living in the U.S. The Centers for Disease Control and Prevention (CDC) confirmed the first Ebola case in the U.S. on September 30, 2014 followed by three additional cases that were widely reported subsequently (CDC, 2014; Rolison & Hanoch, 2015). While the World Health Organization (WHO) deemed the 2014-2016 Ebola outbreak “a public health emergency of international concern” (Alexander et al., 2015; WHO, 2014) the actual risk of contracting the virus in the U.S. was small. Media coverage of the outbreak was high and there were several news reports of African immigrants being stigmatized, negatively targeted and even physically assaulted (Allday, 2014; Brown, & Constable, 2014; Montford, 2014; Muhammad, 2014; Rolison & Hanoch, 2015). While disease-related stigma leads to heightened fear, isolation, and mutual distrust, existing research has shown that changing perceptions of Ebola survivors were essential in easing community tensions and eradicating the outbreak (Davtyan, Brown, & Folayan, 2014; Hitchen, 2014).

It is important to note that Ebola-related stigma, much like any other disease-related stigma, can lead to negative stereotypes about the groups affected. Such stereotypes and associated maltreatment can represent another barrier of adjusting to life in another country. As existing research on the acculturative experiences of African immigrants in the U.S. is scant (Obasi & Leong, 2010; Orjiako & So, 2014)

one must note how benchmark events, such as the Ebola 2014-2016 outbreak, have impacted the complex ongoing acculturative experiences of West African immigrants. For African immigrants who are adjusting to life in the U.S. it is important to recognize that disease-related stigma may represent another acculturative stressor or barrier to thriving in a host country.

CHAPTER 2

LITERATURE REVIEW

Background of Ebola Epidemic 2014-2016

The earliest cases of Ebola can be traced as far back as 1976 with cases in Sudan (Galas, 2014) and subsequent outbreaks in the Democratic Republic of the Congo and Gabon (Alexander et al., 2015; Galas, 2014). While Ebola is not new to Africa, the West African Ebola outbreak was the largest ever documented. It contrasted dramatically from prior outbreaks in its duration, number of people affected, and geographic extent (Alexander et al., 2015). The West African outbreak started in Guinea in December 2013, and heavily affected the neighboring countries of Sierra Leone and Liberia (Alexander et al., 2015; Centers for Disease Control and Prevention, 2015; Tosh & Sampathkumar, 2014). The Ebola epidemic also spread to other countries such as Nigeria, Senegal, Italy, Mali, Spain, the United Kingdom and the U.S. However, the numbers of cases in those countries were significantly lower.

The Ebola virus disease (EVD) outbreak of 2014 was identified as the worst epidemic in the history of the disease, with a survival rate of only 53% (Davtyan et al., 2014). According to the CDC, there were 3,814 total cases of Ebola in Guinea, 14,124 cases in Sierra Leone, and 10,678 cases in Liberia (CDC, 2016). It is a disease characterized by a hemorrhagic fever and severe illness including multiple organ failure with a high mortality rate (Alexander et al., 2015; Tosh & Sampathkumar, 2014). The first case of Ebola was diagnosed in the U.S. in a patient who had recently traveled from Liberia to Dallas, Texas. He later died due to health complications

(CDC, 2014; Tosh & Sampathkumar, 2014). While there were only four reported cases of Ebola in the U.S. and one death, it was very impactful. Studies have noted that even though the risk of contracting the virus in the U.S. was small, the Ebola epidemic received extensive coverage in the U.S. media, with close to 1,000 segments about the virus airing between October 7 and November 3, 2014 on the news (Gertz & Savillo, 2014; Rolison & Hanoch, 2015). Even while the actual risk of contracting Ebola in the U.S. was low, it may come as no surprise that the psychological impact of prolonged news reports could have increased levels of perceived risk of exposure. Furthermore, existing literature suggests that media focus on emotive topics can give rise to biased public perceptions that exaggerate the risk of rare events (Frost, Frank, & Maibach, 1997; Rolison & Hanoch, 2015).

The Impact of Perceived Risk & Disease-Related Stigma

A study by Smith (2006) on the role of the media in risk communication during the severe acute respiratory syndrome (SARS) outbreak mentioned that “the public typically base their decisions on the perceptions of risk rather than actual risk” (p. 3116). This study also noted that even though SARS presented some medical risk, it exerted a large psychological impact on people relative to its low prevalence and mortality rates, partially attributed to rapid transmission of information through the media. (Smith,2006). As Ebola virus disease is known to have very high mortality rate and virtually no identified cure or vaccine, repeated messages about the uncertain course of the epidemic could have easily heightened concerns about it among the general population.

Additionally, existing research has indicated that misperceptions of risk can lead to inappropriate reactions during an epidemic, such as stigmatization of individuals who are perceived as possible sources of infection (Rübsamen,2015). As Ebola is a disease with high fatality rates, existing literature has shown that it is a punishing disease that targets individuals and families. It imposes shame or disgrace on people who are impacted, regardless of whether they are sick, healthy or have recovered (Cheung, 2015). Due to the severity of the disease, any association with the Ebola outbreak whether it is direct, indirect, actual or perceived may present a serious threat. When sources of harm are difficult to identify or understand, fear is easily generalized to any person who falls ill or who has anything to do with anyone who has fallen ill. Their presence alone becomes a threat to one's life and well being which can result in individuals using extreme measures to counter that perceived threat (Garoff, 2015). While there were higher prevalence rates and death tolls of Ebola in West Africa compared to the U.S., it is important to note that misperceptions of risk may lead to the stigmatization and maltreatment of African immigrants residing in the U.S.

As stigmatization continued during the outbreak, more efforts were being directed at speaking up about harassment and working with African advocacy groups in order for individuals to “target Ebola, not Africans” (Crossnan, 2014). As African immigrants faced stigmatization and maltreatment due to Ebola related fears, it seemed to mimic the stigma exhibited towards individuals living with HIV/AIDS. A study by Davtyan and colleagues (2014) noted the similarities between Ebola and

HIV/AIDS stating “the idea that EVD only affects certain groups such as poor Africans and African immigrants is comparable to HIV/AIDS as it was attributed to homosexuality in the early days of the epidemic” (p. 2). Furthermore, this study mentioned that communities impacted by HIV/AIDS and Ebola-related stigma have both suffered from isolation and ostracism, physical violence, and diminished quality of life (Davtyan et al., 2014).

Existing research also suggests that during an Ebola outbreak, psychosocial support diminishes as self-protection drives people to a sort of individuality (Garoff, 2015; Paglia, 2013). Weiss, Ramakrishna, and Somma (2006) note that the emotional impact of social disqualification and cultural meanings of illness signify the various ways by which stigma operates. A cultural shift in the context of a historical event such as fear of Ebola is particularly salient among African immigrant populations because individuals from West Africa usually maintain close relationships and alliances. The threat of disease can shatter families and communities (Garoff, 2015; Paglia, 2013). Thus the stigma of Ebola could simultaneously increase stress and decrease social support.

Stigma, Historical Events and The Complexities of Acculturation

Ebola-related stigma is noted to persist in individuals even after treatment (Cheung, 2015). Beyond those actually infected, and troubling for the wider community is the fact that African immigrants without a history of Ebola can be targeted and stereotyped simply on the basis of their cultural background. Research has shown that another concerning aspect of health-related stigma occurs when

marginalized groups become more vulnerable to health problems, because they are identified with other targets of stigma, such as poverty, ethnicity, sexual preferences, and other factors that may contribute to social disadvantage or discrimination (Weiss, Ramakrishna & Somma, 2006). Given the number of acculturative stressors that immigrants already have to endure upon resettlement in another country (Lee, Koeske, & Sales, 2004; Mori, 2000), the recent Ebola outbreak and associated stigma represent additional acculturative stressors among African immigrants.

While acculturation has been described as the process of adapting to a culture involving the transition that takes place as a result of contact between two differing cultures (Berry, 1997; Flannery, Reise, & Yu, 2001), other theoretical frameworks note that acculturation is an ongoing, complex and fluid process. Berry's fourfold theory is the most widely used model of acculturation and has received substantial empirical support in various studies; however, existing research notes that it lacks flexibility rendering acculturation a static concept (Amoah, 2014; Bhatia & Ram, 2009). It is important to recognize that the "immigrant identity is one that is negotiated and reconstructed in the market place on varied cultural encounters" (Amoah, 2014, p. 127). In other words, during an ongoing acculturative process, the identities of Sierra Leonean immigrants may be destabilized or even re-negotiated because of Ebola-related stigma.

Other Theoretical Models of Acculturation

As the identities that immigrants construct during their migration experiences are also known to be fluid and complex, additional models of acculturation must be

utilized to capture such nuances. According to social identity theory, another concept that has examined immigrant identity behavior is that “groups will react to insecure social identity by searching for enhanced group distinctiveness” (Amoah, 2014; Tajfel & Turner, 1986, p. 22). As immigrants come in contact with a new host culture, they attempt to construct their identity by comparing and finding commonalities between cultures. Perceived inconsistencies in both cultures can create suspicion and insecurities for the immigrant, which further creates questions about their own cultural identity and that of the host culture (Amoah, 2014; Cinnirella, 1997). This questioning and renegotiating process is referred to as “identity-differentiation” (Amoah, 2014; Grant, 2007, p.7). Social identity theory further postulates that identity differentiation becomes stronger when a sense of threat and insecurity is suspected.

Other theories such as the self-categorization theory note that immigrants gradually define their identity through self-introspection in relation to the out-group taxonomy (Amoah, 2014; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987; Wyer, 2010). Social rejection of individuals is more likely to recoil in their in-group (Amoah, 2014; Knowles & Garder, 2008). In contrast to psychological models of acculturation, the notion of “diasporas” has become increasingly utilized to understand immigrant experiences. Within the last decade there has been an emergence of a distinct area referred to as “diaspora studies” (Bhatia & Ram, 2009). Existing research posits that the idea of the diaspora refers to “immigrant communities who distinctly attempt to maintain (real and/or imagined) connections and commitments to their homeland and

recognize themselves and act as a collective community” (Bhatia & Ram, 2009, p. 141). In a study examining acculturation among Indian immigrants, Bhatia and Ram (2009) found that Indian immigrants living in the U.S. renegotiated their acculturation status after the events of 9/11. They noted that culture is often a ‘positioning’ and the acculturative experiences of immigrants are often shaped by various historical and sociopolitical contexts. However, in order to fully understand this ‘positioning’ existing literature asserts that researchers must work to understand the contextual factors that influence how individuals enter the acculturation process, what influences their adaptation, and how this process may change over time (Bhatia & Ram, 2009; Cabassa, 2003; Schwartz, Unger, Zamboange & Szapocznik, 2010). It is also important to understand the characteristics of the migrants themselves, the countries from which they originate, and the country and local communities in which they settle (Schwartz et al., 2010).

Bhatia and Ram (2009) reported that their study participants who were once well integrated into the life and culture of the U.S. questioned and renegotiated their identities as American citizens after experiences of stigmatization following the events of 9/11. It is important to highlight the context-specific factors that led to a renegotiated identity. As researchers have attempted to expand beyond dimensional frameworks of acculturation, in order to address the additional complexities and context-specific factors that impact the adjustment of migrant groups, it is argued that in order to truly understand acculturation researchers must be open-minded and draw from various epistemological and methodological approaches (Bhatia & Ram, 2009;

Chirkov, 2009). Mixed-method and qualitative approaches may create a better knowledge base for understanding what mechanisms influence the acculturative process and what factors are uniquely shaped by the process of adapting to new cultural environment (Cabassa, 2003).

The current study aims to expound upon Berry's acculturation theory, by using the conceptual foundations of social identity and self-categorization theories alongside the work of Bhatia and Ram (2009) and to qualitatively explore whether Sierra Leonean immigrants also renegotiate their respective acculturative status following the recent Ebola outbreak within the U.S. Recent reports have indicated that Sierra Leone and Liberia have only recently emerged from civil war. The instability caused by the Ebola outbreak could drive these countries back into civil unrest (Lapides-Wilson, 2015). Just as the impact of the 11-year civil war in Sierra Leone reverberated across the shores to affect immigrants living in the U.S. (Cole, 2015), the recent Ebola outbreak may illustrate another rippled impact on Sierra Leone immigrants in the U.S. While Sierra Leonean immigrants are comprised of a diverse group of individuals who may, or may not, have experienced pre-migration trauma during the war in Sierra Leone, there are still various factors that may impact their level of acculturation within the U.S. In light of the 2014-2016 Ebola outbreak one may wonder if Sierra Leonean immigrants experienced or even participated in discriminatory actions against others within their community. While this study is exploratory in nature, one may suspect that there have been instances of social distancing and stigma from outsiders as well as from others within the Sierra Leonean

community. Moreover, experiencing and exhibiting Ebola-related stigma could influence the social ‘positioning’ and ongoing acculturative processes of Sierra Leoneans who are settled in the U.S. As few studies have examined acculturation specifically among people of African descent, it is important to consider culture-specific elements of the acculturative process (Obasi & Leong, 2010; Orjiako & So, 2014).

Purpose of Study

The present study used semi-structured interviews to qualitatively explore how the 2014-2016 Ebola epidemic impacted Sierra Leonean immigrants living in the U.S. More specifically, the study aimed to describe Sierra Leonean immigrants’ experiences with Ebola-related stigma and perceived risk for Ebola as part of their ongoing acculturation experiences.

This study addressed the following research questions:

1. How do Sierra Leoneans in the U.S. describe how they were impacted by the Ebola epidemic of 2014-2016?
2. Did they experience and exhibit Ebola-related stigma?
3. Did Ebola-related stigma impact their acculturative adjustment in the U.S.?

CHAPTER 3

METHODOLOGY

Participants

The current study included ($n=15$) individuals who were originally from Sierra Leone and were recruited through flyers and emails from a community organization. A subset of the participants ($n=2$) had previously participated in a qualitative research study conducted by the researcher examining their acculturation experiences and psychological adjustment after the civil war in Sierra Leone (Cole, 2015) and expressed interest in the current study. Nine (60%) participants were men, while six (40%) were women. Five participants (33%) lived in the Washington D.C. metro area, and 10 (67%) lived in the metropolitan area of Atlanta, Georgia. The sample all identified as Sierra Leonean but varied in ethnic background, Krio ($n=6$, 40%), Temne ($n=2$, 13.3%), Mende ($n=1$, 6.7%), Fula ($n=2$, 13.3%), Kono ($n=1$, 6.7%), and Multi-ethnic ($n=3$, 20%). Participants ranged in age from 26-61 ($M=43$, $SD=13.8$). All participants reported having some degree of university education including some college ($n=1$, 6.7%), bachelor's degree ($n=9$, 60%) and a graduate degree ($n=5$, 33.3%). Length of time in the U.S. ranged from 1-35 years ($M=15.3$, $SD=11.9$). Additional demographics can be seen in Tables 1 and 2.

The sample size in this study ($n=15$) is smaller than samples used in quantitative studies. However, it is consistent with the sample sizes usually found in qualitative studies that usually range from 5 to 25 participants (Kvale, 1996).

Table 1.
Demographic information about study participants.

Participants	Gender	Current Age	Ethnic Group	Languages Spoken ¹	Relationship Status	Education
Sarah	F	29	Sherbro/ Temne	Krio	Single	Graduate degree
Robert	M	43	Krio	English	Married	College degree
Tania	F	26	Fula/ Temne/Krio/ Limba	Krio/English	In a relationship	College degree
Leo	M	32	Krio	Krio	Married	Graduate degree
Thomas	M	59	Kono	----	Married	College degree
Marcus	M	43	Fula	English	Married	College degree
Nelson	M	34	Fula	English	Married	Graduate degree
Kenneth	M	32	Temne	English	Single	College degree
Brian	M	29	Mende	Krio	Married	College degree
Patricia	F	60	Krio	Krio/English	Married	College degree
Deborah	F	50	Krio	English	Married	Graduate degree
Francis	F	61	Krio	Krio/English	Married	College degree
Peter	M	61	Krio	Krio	Married	Some college
Lucas	M	28	Temne	English	Single	College degree
Tina	F	56	Krio/Mende	Krio	Married	Graduate degree

*Note*¹ Refers to language spoken most of the time. Even when not explicitly stated, all participants were fluent in English.

Table 2.
Demographic information about study participants continued.

Participants	Job	Job Title	Years in U.S.	Initial Status	Status Change	New Status	Healthcare Access	Mental Health
Sarah	N	N/A	3 yrs. 8 mo	Visitor's visa	Y	PR ¹	N	N
Robert	Y	Self-employed	32	Visitor's visa	Y	U.S. Citizen	Y	Y
Tania	Y	Mental health clinician	25	Visitor's visa	Y	U.S. Citizen	Y	Y
Leo	Y	Console officer	4	PR ¹	N	N/A	Y	N
Thomas	Y	IT	10	PR ¹	Y	U.S. Citizen	Y	N
Marcus	Y	Banker	18	PR ¹	Y	U.S. Citizen	Y	N
Nelson	Y	Teacher	4	PR ¹	N	N/A	Y	N
Kenneth	Y	Parking Attendant	3	PR ¹	N	N/A	N	N
Brian	N	N/A	1	Visitor's visa	Y	PR ¹	N	N
Patricia	N	N/A	35	Visitor's visa	Y	PR ¹	Y	N
Deborah	Y	Teacher	--	PR ¹	Y	U.S. Citizen	Y	N
Francis	Y	Data technician	25	Visitor's visa	Y	U.S. Citizen	Y	N
Peter	Y	Marketing specialist	10	Visitor's visa	Y	U.S. Citizen	Y	N
Lucas	Y	Senior rep	15	PR ¹	Y	U.S. Citizen	Y	N
Tina	Y	Manager	29	Student visa	Y	U.S. Citizen	Y	N

*Note*¹ Refers to the immigration status of Permanent Resident

Measures

The participants were asked to complete a demographic questionnaire and were prompted to respond to questions during the semi-structured interview. A detailed description of the measures used is listed as follows.

Demographics.

Participants were instructed to provide basic demographic information including current age, gender, ethnicity, language(s) spoken, relationship status, education, employment, length of time in the U.S., immigration status, whether or not they had access to healthcare, and if they ever received mental health counseling services (Appendix A).

Semi-structured interview.

A semi-structured open-ended interview was utilized to explore the participants' knowledge of Ebola, experiences with Ebola-related stigma, perceived risk for Ebola, and resulting acculturation experiences (Appendix B). Items exploring perceived risk for Ebola and sources of information and preventative measures were adapted from Rübsamen's (2014) Ebola the Risk Perception in Germany survey, and Rolison and Hanoch's (2015) online survey assessing Ebola knowledge and risk perceptions. Questions addressing acculturation were guided by examining the Measurement of Acculturation Strategies for People of African Descent (MASPAD) scale (Obasi & Leong, 2010), the short version of the Padilla SAFE acculturative stress measure (Mena et al., 1987), and Bhatia and Ram's (2009) assessment of cultural identity in the context of historical events.

Previous research has shown that utilizing an interview guide assists the researcher in obtaining information from all participants as well as providing some sequencing and guidance without interfering with the flow of the participant's reflection (Polit & Beck, 2008; Seidman, 2006). Throughout the interview process, informal member checking and follow-up questions were used to verify participant responses and validate that the descriptions truly reflected the voice of the participant and were not imposed by the views of the researcher.

Procedure

Following the approval of the University of Rhode Island Institutional Review Board, a non-probability purposive convenience sampling (Polit & Beck, 2008; Richards & Morse, 2007) approach was used to recruit participants. The president of the non-profit organization, *Friends of Sierra Leone*, assisted with the recruitment process. This organization aims to promote and celebrate African culture and is widely regarded as a major advocate for Sierra Leonean issues. *Friends of Sierra Leone* is based in Washington D.C. with several chapters and officers throughout the U.S. Flyers along with a copy of interview questions (Appendix C) were distributed via email listserv in the Washington D.C. and Atlanta's metropolitan areas. Participants from a previous study conducted by the researcher (Cole, 2015) were contacted primarily to share the results of that study. Those who met the inclusion criteria for the present study were given a brief explanation of the study and were given the option to contact the researcher at a later time to ensure their participation (Appendix D). Eligible participants were at least 18 years of age, lived

in the U.S. for at least 6 months, and were able to understand, read and speak the English language.

From January to early March 2018, follow-up phone calls and email messages were made to schedule interviews. Fifteen face-to-face interviews ranging from 15-to 60-minutes took place in the participants' homes or at mutually agreed upon public locations (e.g., outside patio of coffee shop, bookstore, or restaurant). At the public locations the researcher mindfully chose a quiet location where others could not hear the detailed account of interview responses.

Prior to the interview the purpose and process of the research study as well as the risks and benefits were discussed with each participant. Participants were asked to explain their understanding of the study for clarification and then were asked to sign a consent form (Appendix E). As this study involved the use of audio recorders, participants were also asked to consent to having the interview recorded. They were also asked if they would be interested in participating in future studies conducted by the researcher.

The demographic form was administered first, and then the semi-structured interview was completed. Upon completion of the interview, participants were compensated with a \$25 gift card in appreciation for their time.

After all the interviews were conducted, the transcription company, *TranscribeMe*, professionally transcribed all of the qualitative data. All transcriptions were also edited several times by the coding team in order make sure verbatim responses were accurately captured. Data were also edited to eliminate all possible

identifiers, and participants were assigned pseudonyms to ensure confidentiality. These pseudonyms were then linked to randomly selected ID numbers in order to provide links between interview and demographic data.

Several precautions were taken to safeguard the participation of the individuals within the current study. If the interview proved to be emotionally difficult, a number of identified mental health and support agencies located throughout the metro Washington D.C. and Atlanta, Georgia areas were made available to participants (Appendix F). The list of referral agencies was identified after each site was called and was found to have experience working with African populations. Fourteen participants declined a follow up call for emotional well-being and one participant was called 2-5 days post-interview to “check-in” about her well-being and a referral was made to an agency. The participants were asked to provide their contact information for follow up on a separate form (Appendix G) and were assured that any forms with identifying information would be kept completely separate from demographic and interview data. Such efforts were taken as the literature suggests that qualitative researchers should demonstrate another aspect of competence, consisting of having sufficient knowledge of the potential consequences of an intense interview and acting to provide appropriate follow-up support (Haverkamp, 2005; Lowes & Gill, 2006; McCosker, Barnard, & Gerber, 2001).

Benefits of Being a ‘Partial’ Cultural Insider

Previous research has noted that one of the most important strategies to employ when designing and implementing a study with immigrant populations is

working with a cultural insider (Birman, 2005). Existing research also states that studies conducted within ethnically diverse populations should contain cultural norms so that the research might be of benefit to participants and their communities and not cause any harm (Begum, Walsh & Lorenzetti, 2014; Liamputtong, 2008). Moreover, the literature suggests that researchers working with ethnically diverse populations should work towards cultural competence by building rapport with research participants and developing trusting, long-term relationships. Such efforts require researchers to remain in or with cultural communities for extended periods of time (Begum, Walsh & Lorenzetti, 2014; Liamputtong, 2008).

Throughout this project, this researcher benefitted through collaboration with *Friends of Sierra Leone*, which aims to promote and celebrate African culture. This organization is widely regarded as a major advocate for Sierra Leonean issues in the United States. This researcher's parents are originally from Sierra Leone and have maintained their cultural identity. As a partial insider this author shared her cultural identity with the research participants and was able to identify *Friends of Sierra Leone*, as a collaborating agency to work with through existing connections within the Sierra Leonean community.

Moreover, a connection with *Friends of Sierra Leone* had been established in 2013 for a previous research study (Cole, 2015). At the conclusion of that study, the research participants gave the recommendation to “go to the ground” in order to understand the people of Sierra Leone and their specific needs. This process of “going to the ground” is an important part of building cultural competence within

understudied populations as it involves spending extended periods of time with the population as recommended by the literature (Begum, Walsh & Lorenzetti, 2014; Liamputtong, 2008). As a partial cultural insider this author's involvement with *Friends of Sierra Leone* continued beyond the realm of the previous study. This author became a member of the organization, learned more about issues relevant to Sierra Leone, and met the president of the organization and several board members who assisted with the recruitment of research participants for the current study.

This author was inspired to continue exploring the adjustment of Sierra Leoneans within the U.S. during the Ebola outbreak. Shortly after collecting data from the previous study (Cole, 2015), this author witnessed family members who both experienced and exhibited Ebola-related stigma in 2014. Given the severity of the Ebola outbreak and the historical relevance of this research topic, this author felt called to stay connected "to the ground" by continuing research efforts with the aim of benefitting the Sierra Leonean community in some way.

Additionally, previous research participants were contacted to share the results from the previous study in the form of a brief report. Study results were also shared with *Friends of Sierra Leone*, members of the Sierra Leonean community and the participants within the current study to demonstrate the importance of conducting research on Sierra Leonean issues and illustrating how research can be translated into ongoing action. This process of sharing qualitative research findings with participants is known as member checking and is noted to increase study credibility and participant involvement (Goldblatt, Karnieli-Miller & Neumann, 2011). Sharing the

results from the previous study and continuing the collaboration with *Friends of Sierra Leone* definitely expedited the recruitment of participants and the data collection process for the current study.

This ongoing connection with the Sierra Leonean community has afforded this author the opportunity to learn about other Sierra Leonean organizations within the U.S. such as *Krio Descendants Union*. Being embraced as a guest in many of the participants' homes was striking. After the interviews were completed, many of the participants ($n=11$) wanted to share their feelings about the current state of Sierra Leone and urged this author to continue research efforts beyond the current study. The matched cultural identity of the participants and the researcher proved to be beneficial not only because of the familiarity and understanding of the culture, but also the personal investment to act ethically according to the culture of the research participants and the culture of the researcher (Birman, 2005; Tapp, Kelman, Triandis, Writsman, & Coelho, 1974).

It is important to note that despite a cultural identity with the research participants, this author represents a partial cultural insider. While this author is familiar with the customs, language, and other cultural nuances found within Sierra Leonean culture, she remains an outsider to the experience of adjusting to life in the United States. Additionally, aiming to adhere to assumptions consistent with a constructivist line of inquiry within qualitative research, this author believes that participants have constructed the nature of their reality which is then interpreted by the researcher noticing common threads. These constructivist assumptions posit that

“multiple realities exist and data reflects the researcher’s and participants’ constructions of reality” (Buckingham & Brodsky, 2015, p. 145). This reasoning supports the use of descriptive thematic and content analyses utilized in the current study. The aim was to stay true to what the data revealed because it is important for participants among an unstudied population to convey their story. Being a partial cultural insider provided the benefit of establishing rapport quickly with research participants and a developing a sense of trust that their story would be told to benefit their community.

Data Analysis

Manifest content analysis and thematic analysis were used to analyze the data. Manifest content analysis is a systematic form of analyzing transcribed interviews and remains close to the text with minimal interpretation (Sandelowski, 2000). Since this researcher wanted to stay close to the participants’ words, this type of analysis was well suited to this study. Once manifest content analysis was completed thematic analysis was done. Thematic analysis involves the detection of patterns and regularities that typically goes right through the data (Polit & Beck, 2008).

Once the transcriptions of the interviews were completed, they were read several times while listening to the audiotapes for accuracy. Six research assistants, trained by this researcher, assisted with the data analysis. They were divided into three teams, with two assistants in each team. Each team was assigned an equal amount of data to analyze.

Data analysis began with open coding of the data which examined units of data (sentences or phrases). Similar codes were then grouped into categories and counted to determine the number of responses related to that code. Throughout the coding process, memos were written by all coders to capture the formation of initial codes and subsequent revision and refinement of final categories and subcategories. The coding teams engaged in several discussions about the coding process and interpretations until complete agreement was reached. Each coder also independently documented interpretations about the underlying categories and discussed overall potential themes found in the study. The researchers and the six research assistants reviewed all of the potential themes and memos until there was 100% agreement.

Trustworthiness

Trustworthiness in qualitative research is characterized by credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985; Shenton, 2004). Credibility was established through informal member checking during interviews, the use of descriptive codes in the language of the participants, and by double-checking transcripts to ensure that they were verbatim accounts of participant responses. Furthermore, journaling took place throughout data collection and analysis to document and check the biases of the researcher and research assistants. Transferability, or level generalizability, was supported with the use of thick descriptions of research findings. Generating an audit trail of records produced throughout the study supported dependability and confirmability. All memos, journal entries, interview and coding notes were maintained throughout the study.

Trustworthiness was also supported by maintaining communication with a member of the doctoral committee who is an expert in qualitative research.

CHAPTER 4

RESULTS

Knowledge of Ebola Outbreak 2014-2016

Prior to addressing the three research questions, participants were asked about their general knowledge of the Ebola virus, when and how they heard about the epidemic, and whether they felt well informed. Table 3 represents the eight responses that emerged when participants reported their general knowledge of the Ebola virus.

Table 3.
Please tell me what you know about Ebola?

Responses	<i>n (%)</i>
Ebola is deadly	10 (66.7%)
Spreads through contamination	7 (46.7%)
Ebola comes from animals	6 (40%)
First identified in Congo	4 (26.7%)
Ebola comes from eating bush meat	3 (20%)
Has symptoms like malaria	2 (13.3%)
Similar to Lassa fever	2 (13.3%)
You can survive Ebola with convalescent blood	1 (6.7%)

Note. Total does not equal 15 (100%) as some participants reported more than one response to this question.

Ebola is deadly. The majority of participants reported that they knew that Ebola was a deadly virus known to kill people rapidly. For example, **Brian** a 29-year-old participant who formerly worked as a medical doctor in Sierra Leone described the rapid progression of the virus.

“So the initial signs and symptoms that you first see is the ones that I've listed. And followed by that, you then get diarrhea, vomiting. And you tend to see some rash on your body as well. And this is normally also associated with

decreased renal function. That is a decreased function of the kidneys and the liver. Normally, at this stage, that is when some patients they start to bleed, both internally and externally. So, because of that, the Ebola virus disease is actually a very fatal disease. It has a fatal incidence of about 25 to 90 percent meaning the chances of surviving; it's actually pretty slim.”

Spreads through contamination. Seven of the participants reported that they knew Ebola spread through contamination of bodily fluids such as blood and sweat as well as skin-to-skin contact. For example, Tania a 26-year-old participant stated: “It was something that spread because of contamination, through blood, skin, sweat and things of that nature.”

Ebola comes from animals. Six participants reported that they knew Ebola was known to come from animals such as monkeys or fruit bats that were usually found in remote areas. Leo, a 32-year old participant stated:

“It is transmitted by wild animals, especially chimpanzees, monkeys, and bats.”

Another participant, 43-year-old Robert reported: “They never found the actual source, but claims are made that it jumped from animals to humans.”

First identified in Congo. Four participants reported they knew that the Ebola virus originated in the Democratic Republic of the Congo in the 1970’s. Three participants, Robert, age 43, Nelson, age 34, and Thomas, age 56, shared their responses below.

Robert: “Well, I know Ebola was- well, they said it was first identified in Congo in the '70s, the first outbreak.”

Nelson: “The things that I know about Ebola is it started in Congo. I know a little bit of history about Ebola. It started in Congo some years back in the late, I guess, 70s.”

Thomas: “So Ebola, has its origin there in Congo, which was an outbreak in 1977. But as a result of negligence by the international community, disease or the virus was never taken care of, and it was left unattended. From 1977 to 2014, there the virus is as true to self. It's a pandemic disease. It's uncontrollable. And it's untreatable if not taken care of.”

Ebola comes from eating bush meat. While other participants identified that Ebola is transmitted to humans from animals, three participants stated humans are infected from eating those animals, which is commonly referred to as bush meat.

Sarah, a 29-year old participant stated:

“Ebola is a virus that's caused by a bacterium that's found in monkeys. And, for example, back in Africa, when in Sierra Leone people go the bush, it's called bush meat, and they kill these monkeys or these baboons and they eat them, so the bacteria becomes active in the human. So when it becomes active, then the person gets the disease or the virus called Ebola.”

Has symptoms similar to malaria. Two participants shared that the Ebola virus has symptoms that are similar to the symptoms of malaria. Tania, a 26-year-old participant shared an incident where a prominent ambassador who was infected with malaria was convinced that he was infected with the Ebola virus and was making preparations for his perceived demise.

“But the other one that was actually on the news, when they said the Diplomat, he actually contracted-- that one, it was very serious and scary because we were all on the phone because he is a Sierra Leone Ambassador. But then, come to find out [laughter], because he wanted to go see his kids. He's the Minister of [*African country*]. He thought he had the symptoms, got in the car, drove straight from New York, onto Maryland. It was like the type of thing, like, OJ Simpson, when he had those people following him. And he was on the news and everything, telling everybody goodbye, he's going to die. They were ready to welcome him at, I'm not sure if it was [*major health organization*] or [*military base in the northeast*]? I think it was [*military base in the northeast*]. And we're trying to figure out, they already had the clothes, the Ebola clothes, and they already had the airbag, the bubble bag to put him in when he gets there. What they're going to do with the car? Probably burn it. And it's like, come to find out, the man had gas, indigestion, and malaria [laughter]. And Ebola has malaria-like symptoms except for when you vomit and stuff, so he thought he had Ebola. So even to this day, we provoke him.”

Similar to Lassa fever. Two participants who worked in the healthcare industry reported that the Ebola virus was similar to another epidemic, Lassa fever due to the hemorrhagic fever. Tina, a 56-year-old participant shared her knowledge of Lassa fever during the time she worked for a prominent health care organization in the Southeast.

And I was working directly with the hemorrhagic fevers, which Ebola is one of them. I worked on the Lassa fever, which was another epidemic in Sierra Leone. And we had Marburg fever. We had monkey fever which was what Lassa was predominantly in the area where I was assigned which they had the same class as Ebola, the same rate. So I was very familiar with the Ebola outbreak. Well, well more so than anybody else because we have all dealt with this hemorrhagic fevers, we know how they wipe out. Lassa had an incubation period of 21 days—

You can survive Ebola with convalescent blood. Another participant who traveled to Sierra Leone to help during the Ebola outbreak reported that individuals were able to survive the Ebola virus if they received the convalescent blood from another person who survived the virus. Robert, a 43-year old participant stated:

“But we came to find out that when a lot of the Europeans or non-Africans contracted it, they were able to still-- they would survive. So when we did further research, I'm like, what the hell is going on here? We found out that every single one of them received-- it's called convalescent blood. It's basically they received a blood transfusion from Ebola survivors. Right? When somebody survives Ebola-- even though you're still going to have the same symptom, when you survive Ebola, your body-- because Ebola is not 100% fatal. Right? If you can survive long enough for your body to produce antibodies, your body can fight off the virus. And after you survive, you have these antibodies present in your plasma. Now somebody contracts Ebola and

within the first eight days, they receive-- they had an infusion of these antibodies, it gives them a stronger fighting chance to fight off the virus until their own body starts producing. So every single-- and you can do follow-up on it. You can find out every single one of them received blood transfusion of antibodies.”

Participants were then asked when and how they heard about the Ebola outbreak, which is outlined in Tables 4 and 5 below.

Table 4.
When did you first hear about the Ebola outbreak of 2014?

Responses	<i>n (%)</i>
Late 2013	1 (6.7%)
December 2013	1 (6.7%)
March 2014	3 (20%)
April 2014	2 (13.3%)
May 2014	3 (20%)
June 2014	1 (6.7%)
July 2014	2 (13.3%)
In 2015	1 (6.7%)

Note. Total does not equal 15 (100%) as some participants did not provide an answer to this question.

Table 5.
How did you hear about it?

Responses	<i>n (%)</i>
Personal Contact (family, colleague, etc.)	5 (33.3%)
Rumors	5 (33.3%)
The news	5 (33.3%)
Social media	4 (26.7%)
Sierra Leonean embassy	1 (6.7%)
Television	1 (6.7%)

Note. Total does not equal 15 (100%) as some participants reported more than one response to this question.

While a third of the participants reported that they first heard about the Ebola epidemic on popular news outlets including BBC, CNN, and MSNBC (Table 4), the same proportion of participants stated that they first heard about the Ebola outbreak from family, friends, work colleagues, or through the fast-acting rumor mill of Sierra Leone. Participants Deborah, age 50, and Tina, age 56, shared their experiences below.

Deborah: “Well, through family members, because I do have family back home.”

Tina: “I was very fortunate to the Ebola thing because my director who ended up being the director for the Ebola, that even went to Sierra Leone, that's who hired me at [*major health organization*]. So I was in close contact with [*colleague*]. Yeah, because we all stayed in close contact. And that's who first called me about this and said, "Oh, now you understand, oh my God, another epidemic like Lassa.”

Another participant, **Peter**, age 61, referred to the popular rumor mill in Sierra Leone as another viable source. “The bush radio. Yes, it moves fast. So the bush radio is like the word of mouth.”

Moreover, the majority of participants reported that they felt they received information from good sources and were well informed about the Ebola outbreak in Sierra Leone. Table 6 outlines the general impressions of all the participants below.

Table 6.

Was that a good source of information for you? Did you feel well informed?

Responses	n (%)
Felt well informed	12 (80%)
Felt uninformed	2 (13.3)
Felt informed after further research	1 (6.7%)

Some participants stated that they did not feel well informed about the Ebola outbreak because the government of Sierra Leone did not initially confirm it. For example, Sarah, age 29 stated:

“No because it wasn't official, so I didn't take it seriously. I was like, "Oh, it might be something, and they're just trying to-- propaganda." You know Africa. When things happen, you'd be like, "Oh, it's just a political thing." So I didn't take it seriously because when I was there, it wasn't officially declared. So I never took it seriously. I was like, "Oh, probably just some normal thing that's happening.”

Another participant, Robert, age 43, stated that he did not feel fully informed about the Ebola epidemic in Sierra Leone until he did his own investigation of historical research.

“I felt better informed actually when I started reading more research, more historical research on the virus because there's a lot of controversy associated with Ebola and how it got to Sierra Leone. Because there's nowhere-- well, how does a virus jump like three countries from Congo end up in the Mano River basin?”

Participants were also asked where they would go to get good information about the Ebola epidemic. The following eight responses emerged and are outlined in Table 7.

Table 7.

If you wanted to get good information about Ebola where would you go?

Responses	n (%)
Health agencies (CDC, WHO, NIH)	10 (66.7%)
International News	5 (33.3%)
Internet	5 (33.3%)
Ministry of Health	2 (13.3%)
People in Sierra Leone	3 (20%)
Social Media	1 (6.7%)
Historical Research	1 (6.7%)
Radio in Sierra Leone	1 (6.7%)

Note. Total does not equal 15 (100%) as some participants reported more than one response to this question.

The majority of participants reported that they would go to the websites of prominent health agencies including the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), or the National Institutes of Health (NIH) to obtain reliable information about the Ebola epidemic. A third of the participants reported they would rely on international news outlets or the Internet. A smaller proportion of participants reported they would rely on the ministry of health in Sierra Leone, people in Sierra Leone (e.g., Ebola survivors, friends, and loved ones), or social media outlets like Facebook or WhatsApp. Five participants, Marcus, age 43, Brian, age 29, Robert, age 43, Kenneth, age 32, and Tania, age 26 all shared their thoughts below.

Marcus: “To get the educational part of it I would go to CDC's website.”

Brian: “Well, WHO is one, for example, because they did a very good job during the Ebola outbreak. They played a very important part in the work. And there were books that came out afterwards. So one major source of information about Ebola would be to go to the WHO website. You can find a lot of useful information about what happened and some of the studies that were done.”

Robert: “More the international news, and there's a lot of literature out there on Ebola. And a lot of the international news covered it well.”

Kenneth: “So those really affected in Sierra Leone. Yeah, and that was us friend because people that survived the disease, and these are the people you need to talk to because they can give you firsthand information about the disease.”

Tania: “Of course, the Internet. WhatsApp and Facebook, yes.”

Research Questions

The purpose of the individual interviews ($n=15$) were to explore how the 2014-2016 Ebola epidemic impacted Sierra Leonean immigrants living in the U.S. The following research questions guided the study: 1) How do Sierra Leoneans in the U.S. describe how they were impacted by the Ebola epidemic of 2014-2016? 2) Did they experience and exhibit Ebola-related stigma? 3) Did Ebola-related stigma impact their acculturative adjustment in the U.S.?

The results are displayed under each research question.

Research question #1 How do Sierra Leoneans in the U.S. describe how they were impacted by the Ebola epidemic of 2014-2016?

Participants' descriptions of how they were impacted by the Ebola epidemic are described under two categories: 1) pervasive fear and 2) preventative actions.

Pervasive fear.

The majority of participants (n=13) stated they were worried a great deal about the Ebola epidemic of 2014-2016. All participants reported that this sense of worry was pervasive across the Sierra Leonean community in the U.S. and throughout the diaspora.

Only, two participants, Sarah, age 29, and Tania, age 26, stated that they did not initially worry about the Ebola epidemic when they first heard about it due to propaganda and not having the full information about the epidemic in the U.S. For example, **Tania** states:

“I didn't know what Ebola was at that moment, I felt informed enough to know, but we didn't take the emergency that serious. At that time, we didn't have none of the information of the demographics, of the seriousness, the statistics. So it's just like, Okay. Well, maybe 4 people died, that's it. We didn't even know people were dying. When they started say that once you contract it, you have 12 days to live, that's when it got serious.”

A number of participants reported that they had a personal risk of acquiring the Ebola virus due to the unknown course of the epidemic, its debut in the U.S. and because some engaged in international travel or traveled to Sierra Leone at the time.

Four participants, Tania, age 26, Nelson, age 34, Thomas, age 59, and Robert, age 43, shared their thoughts below.

Tania: “Yes. Just because of the fact with the people-- and, of course, the people that were escaping. That were coming here really quick, to stay, and didn't know, Okay. Are you staying to try to get away or to get medical attention because you have it? We don't know.”

Nelson: “I think everyone has a risk of acquiring a disease, not only Ebola. Of course, yes, I think I do have a risk and everyone else has a risk because take into consideration HIV like 25, 30 years ago. It was just in a specific place that we were talking about it. But now, it's a worldwide disease. It's all over the place. So if I have many diseases or things that spread out that people doesn't expect like actually to spread out like that, but it happens to spread out. So I think everyone is liable to acquire it, basically.”

Thomas: “Yeah because I'm traveling. I travel out, come in. Every person at risk, especially in different international airports.”

Robert: “In Sierra Leone, yeah, man, sure. It's surreal, man, because when you first land in the airport, you really do see like you see on TV, the people, the masks and the gloves. You got to wash your hands. Everybody got to go wash their hands with chlorine. So the first day or two, you're scared because you don't know. And then you get news of, Oh, did you know that person? Like, for example, where [*family member*] lived, the mosque where her daughter goes to, one of the guys got Ebola. I was real all over the place.”

Other participants reported that they felt they were not at risk for acquiring the Ebola virus because they were located in the U.S. where many precautions and preventative measures were put into place to contain the spread of the virus. For example, three participants Leo, age 32, Sarah, age 29, and Deborah, age 50 stated:

Leo: “Not at all. Because I'm in the U.S. and it's safer here.”

Sarah: “No, because I was here [laughter], and then I think there was a ban on the travel within and to these countries, my country Sierra Leone, Guinea, Liberia so I wasn't threatened even though there was somebody that came to the United States that apparently had it, I was like, "Eh." I mean, I'm like, "I'm fine.”

Deborah: “Not really because are certain precautions that we're taking unless-- because at the time, I did not think of traveling, of going back home because I knew that if I do that, I would expose myself to it, and I didn't want to.”

Four participants reported that they were directly impacted in the United States by instances of discrimination; others reported they were generally worried about the impact that the epidemic would have in the U.S. The following four participants, Leo, age 32, Nelson, age 34, Marcus, age 43, and Deborah, age 50, shared their accounts of how the Ebola epidemic impacted them when cases were found in the U.S.

Leo: “I was so worried knowing that this thing can spread from Africa to America.”

Nelson: “I was getting more worried, not only for myself but, like, people travel, and if people that's went to Sierra Leone were infected by the disease and it was discovered in the USA, I was getting worried like, okay, how is it going to look like for people, not only for people who are in West Africa, but how the interaction is going to look like? So it was kind of scary and worrying a little bit.”

Marcus: “It was very minimal. People knew me for who I am and they knew my background, so they would just ask questions, "Hey, you. It happened there. Is everything okay?" So I guess it's my-- the demographic area I find myself, it's not as hyped. I know the experience, where it's probably different for others in Sierra Leone and African communities wherein they have firsthand cases of people traveling back and forth. So as for me here it was completely different.”

Deborah: “Well, I just did not think about it because the cases were few. I think it's about two people. And then they were not in my local vicinity. My focus was on Africa. And knowing that these people here were taken care of, so that was not my concern.”

Another participant, **Francis**, age 61, expressed concern about the Ebola screening process that was used for individuals entering the U.S.

“Well, at first, I felt bad about it because I thought if it was well-- if these people coming in was well screened, it would not have been in the United States. Although the people too, according to the news, we heard that this

person from Liberia, I think that's the first person I could think about, he came into the country. He knows he was sick, but, of course, I will not blame him because he was trying to-- you don't want to die. So he knows he was sick, according to the news, he knew he was sick, and he tried to pop himself in, pop himself up to come into the United States so at least he could be allowed in. So I will not be mad at him because he's trying to-- you don't want to die. But if he was screened properly, he would not be allowed in, but everything is in God's hand, I mean.”

Preventative actions.

As participants were asked to describe the impact of Ebola virus, two participants mentioned that once the Ebola virus reached the U.S. they became involved in either campaigning to spread awareness about the epidemic or worked with other health personnel to equip a U.S. hospital to accommodate patients infected with the Ebola virus. These responses along with participants' descriptions about their changed behavior due to the outbreak, the precautions they would take in the case of another epidemic, and their thoughts about an Ebola virus vaccine emerged to outline the category of *preventative actions*.

Two participants, 28-year-old Lucas and 56-year-old Tina, shared their accounts of how the Ebola epidemic prompted their efforts to spread awareness and prepare for Ebola cases in the U.S.

Lucas: “CNN reported it, but there was no-- there was not much emphasis on it. It was mentioned maybe a few times. I mean, for something that big, you

would think it was an outcry for the world to try to contain it where it is, but it was not that much coverage. That's what prompted the Sierra Leone community in Atlanta for us to go by the [*major health organization*], which is located down the street from where we are currently are, to kind of not demonstrate, but in other words, peacefully protest to bring attention to the situation, to give it more coverage. And we had about three other communities that came together. The Liberian, Sierra Leoneans, and Guinea. And we had some other supports from Americans, friends, and other communities as well that joined us. I think we rallied about over 100-plus people, which was a big traffic. And we had a lot of support. There was a bunch of cars that were coming by, honking at us, just kind of seeing that we had the Sierra Leone flags, the signs reading, [*major health organization*], end Ebola now. Do more.' There was a bunch-- I mean, the cause was really, really-- it was very interesting. I mean, it was the first time for me as a young man that was still active in the community, and I was literally getting out from college at that time. So I was very involved in the bringing awareness.”

Tina: “Well, when the Ebola cases were found in the U.S., the good thing about it is, I was involved again when we had-- I'm a close friend of the council, so they were trying to put an Ebola thing together with the three Mano River Union. There was Guinea, Liberia, and Sierra Leone and to come together and see what we can do. So I was part of that arrangement where we got to see this and it was held at the [*local civic center*] where we even had the

guy that had recovered one from Liberia and the actual doctor. I don't know if I have the picture here we took. The actual doctor at [local university] that had taken care of that man. Well I worked for [local hospital] and the unfortunate thing was I'm over the [de-identified] lab. So I was home that night and I appeared to look at my phone and here's my--[grabs phone] see "Oh, you need to vacate this [de-identified] lab 9 o'clock tomorrow morning." I'm like, "What? Are you serious?" So I got up and I went to work, and I was like now at least let me pull before you lose. Well it was-- what's funny is the fact that we have to convert this into an Ebola-ready place. And the irony, I'm from Sierra Leone.”

Some participants stated that they stopped going out in public and stopped traveling. Two participants stated that they even stopped telling people they were Sierra Leonean due to incessant questioning. However, while one of the participants stated that he refrained from telling others that he was Sierra Leonean, he eventually traveled to Sierra Leone and was very active in the fight against the epidemic. Robert, age 42, and Patricia, age 60, shared their experiences below.

Robert: “Like, in the States, yeah, I changed. I did like I said. With somebody I didn't know, I wouldn't necessarily openly tell them I'm from Sierra Leone. Well, it might be a big change because I went to Sierra Leone so I guess, yeah, I decided that I just felt helpless just being here and that's going on. So that's how it might be a big change when I went to Sierra Leone.”

Patricia: “Well, people that know me as a Sierra Leonean were asking me a lot of questions. Like, "When was the last time you were over there?" Was number one question. And, "Is it affecting your relatives and friends over there?" So pretty much that. And it got to the point where, people that didn't know I was from Sierra Leone, I wasn't telling anybody [laughter]. I was just like shoo. But then people know you're from Africa, and they just think that, Africa and Ebola.”

After participants described the impact that the Ebola outbreak had on them in the U.S., all participants reported that they would adhere to preventative measures in the case of another outbreak. The majority of participants reported that they would pay for a vaccine and three participants reported that they would not pay for a vaccine. The remaining two participants either questioned the effectiveness of a vaccine for Ebola or reported that they would help distribute the vaccine to others but would not use it themselves.

The following five participants, Brian, age 29, Robert, age 43, Tania, age 26, Deborah, age 50, and Tina age 56 shared their thoughts about the Ebola vaccine below.

Brian: “Of course. It's like the flu shots. If you know you can get it in order to prevent it, then why not [laughter]?”

Robert: “No. Because I don't believe-- I don't trust the vaccines. From my observation and my experience, I have zero trust for the people who were put in place to "contain the virus" and people who "creating the vaccine." From

my observation, my experience, the Ebola outbreak was orchestrated and done to observe what a weaponized virus would have on a population.”

Tania: “No, some of them are not effective. Some of them have side effects. Some of them could create more harm than cure. I'm not going to take it. If I had Ebola, hmm, I'd take an allergy pill and pray [laughs]. But as far as the vaccine, like the, what is it? N1H1? No, that's something else. But the vaccine that they said they had, I mean, they never brought it out. So how do we know it works? How do we know that-- it still killed-- not only did it kill the one that it wasn't effective and it killed everybody in the experiment. And by that time, before they all died, they all went and people contracted. That's probably what even happened. You never know. Mm-hmm.”

Deborah: “Well, it depends. If I believe that the vaccine would do that 100%, I will. But telling me 50/50, that doesn't make sense to me.”

Tina: “Maybe not me, I would be willing to subsidize anything that would take care of humanity, not just me that as long as it's going to impact life and save lives, I would contribute. But if I were to do that, I would always specify that you take it first to the place where really they are affected, not people that are 10,000 miles away.”

Research Question #2 Did They Experience and Exhibit Ebola-Related Stigma?

Participants' descriptions that captured Ebola-related stigma are described under one category microaggressions.

Microaggressions.

As participants previously reported that they were impacted by discrimination when Ebola cases were found in the U.S., it may come as no surprise that a larger proportion of participants (53.3%) reported they were treated differently because they came from a country that was impacted by the Ebola epidemic. These responses illustrate experiences of *microaggressions*. Four participants, Tania, age 26, Deborah, age 50, Robert, age 43, and Kenneth age 32, shared accounts of being questioned, having travel plans delayed or experiencing social distancing from others due to being Sierra Leonean during the Ebola outbreak.

Tania: "When they had that question, if you traveled to Liberia, Gambia, Guinea, and Sierra Leone, those kind of stuff. And they make you wear the facemask. Or the CDC for like, 3 months every day, calls you and asks you for your temperature, sometimes they would come and visit you. Or being held at the airport for long and when they're done, they interrogate you and you got to walk with a cell phone, an extra cell phone for like, the next month to 3 months."

Deborah: "Oh, yes. Oh, yes. Everywhere you went, at that time. In fact, just the accent, people are like, "Where are you [coming?] from? Did you travel?" They keep their distance. [...] "Have you recently been to West Africa?" No.

All those [kinds of?] questions that you don't need. So most times, I just don't answer because I mean, I find it offensive.”

Robert: “That's when people started, if you say you're Sierra Leonean, people start giving you the side eye. You know what I'm saying? “When was the last time you been? When was the last time you been?”--But like a lot of people were scared. My neighbor, like when I came-- because I went, I came back and I went again, when I came back the first time, my neighbor, something he said-- well, no, first, my father-in-law, he refused for me to go to his house when I came back. And I thought he was joking and he was serious. Like, "No. You can't come." He was like, "You got to wait 21 days before you come, just in case." I mean, really? And my neighbor, I taught his kid how to bike. You know how somebody is, hey. The kids weren't coming over. It was like all right, okay.”

Kenneth: “Yeah. Basically, before we traveled to America we had to go through medical checkup, everything. Yeah. So we had to go through so many medical stuff that they know that you don't have the disease for you to come to America and have been given the visa from the United States of America. So we traveled on August 1st from Sierra Leone. To Belgium on the 2nd. Then I came to America on the 3rd in Dulles airport. But before we came, when we go through the Dulles airport, so we saw the signs-- people were from Sierra Leone, Liberia, Guinea, you should go this way, so we were totally discriminated. So people were like, "Oh, these guys are from where

they had this Ebola." So we were totally excluded from other people. Yeah. I have to take-- from Dulles I supposed to fly 3:00 PM in the afternoon. Well, I was delayed for the next flight on 7:00 PM to Ohio. So I was like, "Whoa, just because that we came from this." That was my first experience that I felt like I was really discriminated."

Meanwhile, others stated they were not treated differently at all. For instance, Leo, age 32, Francis, age 61, and Sarah, age 29, shared that they were not stigmatized because they were either around their African friends, didn't travel at that time or just felt that people were generally curious about the epidemic.

Leo: "No. Because most of the time I'm with my African friends."

Francis: "Because I did not travel to Freetown years before and after the Ebola, I did not."

Sarah: "Not really...I've heard of people who were stigmatized and stuff, but no. I wasn't treated like-- people were just curious."

Another participant, 28 year-old **Lucas** reported that he felt that he wasn't outwardly treated differently but stated that he did know of people that made jokes about it.

"I wasn't treated differently. Most of the people that brought up the virus, it was more in a jokey manner. And I had to say something once or twice. But after that, I stopped responding. So she would just whatever, and then she realizes it's not funny and she stops."

Research Question #3 Did Ebola-Related Stigma Impact Their Acculturative Adjustment in the U.S.?

Participants' descriptions related to the impact of Ebola related stigma on their acculturation adjustment in the U.S. are described under two categories: 1) the immigrant identity with six sub-categories and 2) longing for 'Sweet Salone'

The Immigrant Identity.

While a notable proportion of the participants did experience Ebola-related stigma and discrimination, the majority of participants stated that such experiences did not impact their sense of belonging in the U.S. This sense of belonging along with descriptions of what they thought it means to be a Sierra Leonean in the U.S. today and their level of community connectedness and involvement encapsulates the category of the immigrant identity with six sub-categories.

Grateful for the land of opportunity. Four participants reported an overall sense of gratitude to move to the U.S. to pursue their dreams and other opportunities. Two participants, Kenneth, age 32, and Peter, age 61, shared their thoughts on being a Sierra Leonean in the U.S. below.

Kenneth: "Wow. Yeah, well, where? Like for me, it was a dream coming to America. Even though at times it's only challenges, it was a dream for me. Because ever since I was coming up, I only wanted to go to America. See if I go over there, I can make my dreams be reality. Because we have these dreams. We have these passions. I want to be this. I want to be that. But it's the best. Coming to America is the best place for me to be in the world to

realize my dreams. So that's why I think-- I think I'm on the right side.”

Peter: “I think it's just a great opportunity. Because we do come here for bigger opportunities which we lacked over there. Being in America, I think, that's a God blessing for us.”

Proud to be Sierra Leonean. Four participants revealed a sense of pride in their heritage as they reflected on what it means to be a Sierra Leonean in the U.S. today. Two participants Francis, age 61, and Marcus, age 43, shared their sense of pride below.

Francis: “I think, one, I'm proud to be a Sierra Leonean. And I'm happy I have the opportunity to come in the United States and improve my life. And I could say thanks to that [laughter].”

Marcus: “It's relatively-- for me, I have pride. I've had pride in myself, my background and to a point it is-- I would say it's domineering as an African, and I know sometimes it overrides even my conscious thinking that-- it's like the lion, more or less, that-- too much pride, basically. Even before Ebola, that's just how I am, and I know a lot of Sierra Leoneans and Africans like that. So I take that very highly. I take pride in my background, and I take pride of who I am.”

Hostility toward immigrants. Other participants expressed that due to the current political climate in the U.S. there was general sense of hostility toward immigrants. Deborah, age 50, and Patricia, age 60, shared their thoughts below.

Deborah: “But if I decide to think about what people think about me and the

way people tend to treat me, especially now with this political climate, after what this man said, people look at you as if you are from-- dangling from dumbness. That's what I would say. Like you do not understand anything. You're not fit to be here. Something like you're below them or something. But for me, it's like I know who I am, and there's nothing you can do to hurt me, to break me. So I keep on stepping.”

Patricia: “But so long as you don't speak the American English, you're always an immigrant. Well, right. That means, in reality, you're not an American [laughter]. Actually, it has become worse with the new president that has made us a little bit more insecure. Before, you felt like you were a part of the whole system. America was a country of immigrants, and we're just a part of it. But now, with a new president and everything, it's making us feel like you should not even be here. Who are you? Like you're here taking up spaces as long as we've been here. It's difficult to turn your TV on every day and see this man that you know don't like immigrants on TV, it is. But as well, we got to deal with, and hopefully, it will just be just four years.”

High expectations to succeed. Other participants mentioned that once they arrived to the U.S. family members in Sierra Leone had high expectations for them to succeed. **Leo**, age 32, shared “It is very challenging, especially leaving your family back home. The expectation is too high. They think you have to get, like, \$50,000 in a one or two-year period.”

Sierra Leone means blood diamonds and Ebola. Some participants stated that

being a Sierra Leonean in the U.S. is associated with the events that have plagued their country. For instance, **Sarah**, age 29, shared her thoughts below.

“Oh, you have so many stories to tell, because the moment you say you're Sierra Leonean, people go like, "Blood diamonds." The moment you say you're Sierra Leonean, people go like, "Oh, Ebola". And it's like you have to have your own story. We're more than the war and Ebola-- I always tell people, if you want to travel-- I always invite them to come to Sierra Leone. I'm like, Yes, what you see in the news, yes, there's poverty and stuff, and we don't have skyscrapers and all these fancy buildings, but if you want to go to most beautiful beaches in the world, you want to experience nature at its best, come to my country. We're more than the 10-year, 12-year war and Ebola. Yes, whenever we try and move 10 places forward, something comes up and we go 20 places back, but that doesn't define us because we're more than that.”

Hope for Sierra Leone. Other participants had hoped for Sierra Leone despite the hardships that were faced. **Tania**, age 26, shares her sense of hope even as others are doubtful.

“That's a good question [laughter]. As for myself, I will be staying woke about what's going on. Being active. Being positive. Having hope. Physically, be a doer, and not a sayer. Sierra Leone, right now, with this whole election situation coming up and everything, it's a lot of chaos. Because you don't know who is the real Sierra Leonean. You have some people who they have hope. You have some people that have been assed out, so they don't have hope

no more.”

Success in the U.S. takes hard work. One participant, who also agreed that the U.S. is the land of opportunity, also reported on the realities of pursuing a dream in the U.S. and how it takes a lot of hard work. **Brian**, age 29 shared his thoughts below.

“Being where I'm from, and now where I'm at, it's pretty good because there's a lot of opportunity and if only you're determined, and focused, and you're ready to work hard. So, for me, it doesn't matter where you come from. It only matters, like I said, how hard you're ready to work and how much you're ready to sacrifice. And because, like I said [laughter], everybody wants to live the American dream, but it doesn't come as easy as in a dream. You'll have to push an extra mile and work hard, so. And I believe, even though I'm from Sierra Leone, I'm as competent and qualified to do whatever I set my mind to. It doesn't matter where I studied or where I'm from because what is being taught in the States is the same as what is being taught back in Sierra Leone.”

While the participants had various views on what it means to be a Sierra Leonean, the majority of participants reported that the sense of being a Sierra Leonean in the U.S. had changed due to the political climates of both the U.S. and Sierra Leone. They also reported that this change was impacted by the overall stability of Sierra Leone after the war, Ebola, and the recent mudslide. One participant, **Peter**, age 61, even reported concern about his status as a dual citizen of the U.S. and Sierra Leone.

“Considering the present circumstances in Sierra Leone, even though it was something they said it was in our constitution back home, by carrying two citizenships, at first we thought that it was okay to have a dual citizenship. Because if I travel, I go out with my Sierra Leone passport and come in with my American passport. But as of now, with all the political atmosphere, they are sort of discriminating and saying that, "You belong to America. You should not participate." Well, not in all cases. For instance, if you want to become president, a minister, they say you are not supposed to have the dual citizenship because you have declared, you have denounced all other citizenship. Yes. Because when you go for the interview, you must pledge your allegiance only to the American government or the flag. We are not looking at it that way in Sierra Leone. So that impact is on me. A lot of people that I talked to from America to go to Freetown to make the election, but because of that, then we are disqualified.”

After participants were asked to define what it means to be a Sierra Leonean in the U.S. today and how that meaning has changed over time, they were then asked additional questions that gauged their current level of acculturation within the U.S. They were asked to think about the general composition of their friendships, any difficulties balancing Sierra Leonean culture with American culture, and their level of involvement within the Sierra Leonean community and other communities in light of the Ebola epidemic.

A larger proportion of participants reported that they have a balanced number of African and American friends and stated that they have not found it difficult to mix their own culture with American culture. Moreover, the majority of participants were actively involved in more than one community within the U.S. The following participants, Nelson, age 34, Robert, age 43, Brian, age 29 and Deborah, age 50, discussed how they were able to integrate aspects of American culture with their culture of origin.

Nelson: “Nothing changed. ... I have a whole bunch of different people. A diverse culture. Americans, Europeans, Africans, yeah. At home, I keep to my traditions and everything. I practice what I believe in and do everything the actual way, but when I interact with people, I blend myself into the culture, because I believe when you travel, you go to a place, for you to be able to be stable and interact well with people, you just have to respect the values and everything of those people. So I respect the laws of America. I respect the Constitution. I try not to violate the laws and-- but at the same time, I practice what I believe in. I practice-- I show that to my kids so that if one day I have to take them home so that it's not like them being in a different world. They have an idea of what's going on down there as well.”

Robert: “No, no because I came when I was young. And then when I came, I was immersed in the American culture and a lot of friends are American. And I grew up in a community in New Jersey that also had a strong Sierra Leonean population. So a lot of us-- it was easy for us to maneuver both being Sierra

Leonean and being American. So I've never found it difficult to maneuver as a Sierra Leonean in America.”

Brian: “Not pretty much because there are downsides to both parts. The American culture has its good parts and its flaws. So does our culture back home, so”.

Deborah: “Nope, because we are from a British colony, and my children attended private school, so they'd be speaking in English at home. And it's because we are Krios, the culture is the same. The way you behave is the same, so it's like there was nothing different.”

One participant, **Deborah**, age 50, described how she did lose some American friends during the Ebola outbreak. However, it did not impact her sense of adjustment in the U.S. because she eventually gained other friendships. “During the Ebola time, I lost a lot of American friends. Yeah. They did not warm up to me, as they used to, and they dropped out along the way. But then I gained a few more after that.”

Some participants reported that even while they were well acclimated to life in the U.S. there were still times when they found it difficult to mix Sierra Leonean culture and American culture. **Patricia**, age 60, shared her thoughts below.

“Yeah. I'm married to an American, and it's like you've got to really watch what you do because it's a cultural thing. Americans have their own culture, and I have mine, like-- okay. Let's say for Christmas, right? If I go to my in-

law's house who are American, they want a big, old turkey and all that stuff whereas I would just be happy with some Jollof rice.”

One participant, **Leo** age 32, who also participated in a previous study by the researcher reported that when he first came to U.S. he tried to balance aspects of Sierra Leonean and American culture but it did not work for him, so he prefers staying primarily involved within the Sierra Leonean community. “When I first came here and I tried to blend the two together, it won't work, so I prefer staying with my family culture, African culture, because our culture is more disciplined. You have to be humble. You have to be in school, you know.”

Longing for ‘Sweet Salone’

Participants described a deep longing for Sierra Leone characterized by the desire to visit and return to Sierra Leone, mixed feelings about leaving, homesickness, disappointment about the current state of Sierra Leone and various ways participants coped with their longing for Sierra Leone while living in the U.S.

The majority of participants reported that they desire to visit Sierra Leone often and also hope to eventually retire there. About a third of the participants reported that they just want to visit Sierra Leone and two participants reported that they want to return to Sierra Leone indefinitely. For example, **Nelson**, age 34, shared his thoughts on returning to Sierra Leone.

“I will visit and-- both, I would say. Visit and I might live there. Sierra Leone is my-- I was born in Sierra Leone. I grew up there. I happened to travel and

lived in France for some time and came to the US. So I have a mixed culture of all those places, but I'll always want to go back. That's my motherland.”

One participant, **Patricia**, age 60, reported that she did not want to return to Sierra Leone because of the current political climate. “I haven't wanted to. I don't know. Well, but that's not because of Ebola. It's because the country's so messed up right now. The president we have there.”

Some participants reported that they were initially very homesick but are now well adjusted to life in the U.S., while one participant reported that she was mainly disappointed with the current state of Sierra Leone due to all that has happened over the years.

Five participants, Peter, age 61, Sarah, age 29, Francis, age 61, Marcus, age 43, and Lucas, age 28, all shared how they felt since leaving Sierra Leone below.

Peter:” For me, I was happy. But in my quiet moments, I do feel homesick a little bit.”

Sarah: “It's an opportunity in disguise. Something negative came out positive for me because, at the end of the day, even though I came on the visitor's visa, and would have gone back home probably-- if I would have gone back home, I would just be working and focusing on making money, then wanting to come finish grad school. So it put me in that place where I had no option but to go to school, which I did. I could say it became an advantage for me, became an opportunity for me. And I'm grateful for that. Yes. All the time. Yeah. I do because it wasn't planned. You understand? So when you plan on

leaving a place, it's already in your mind that, "Oh, I'm going for a particular thing," and that's the focus. But mine wasn't planned. It was a summer holiday that changed to being here almost four years.”

Francis: “Well, when I came in the United States, I was homesick because the war was going on then. My family was over there. I was out of it completely, feeling lonely. Miss my family. But since I was able to get them over here. I'm okay.”

Marcus: “For me it's mixed. I mean, like everybody else, if you're in a different place, you're in a different place. Regardless of how acclaimed you are with it, with the systems or exposure to certain things, there are things that you get to miss from time to time. I'm an outdoor person, very big on outdoors. So in Freetown I'm used to going to the beach at least every afternoon or every evening. I miss that here. The closest I can get to a beach is Savannah on the ocean side. So that's why I get to live as close to water as I can, hence my living in [*current county*] so I have access to the lake. So that mimics my sensibility to the ocean. But apart from that, we get homesick. Foods, that's one, two, the communities. I mean, the sensibility that no matter what, this is home. That's an underlining factor. I don't care how much or how long I live here or my status here.”

Lucas: “Well, I really enjoy where I am now. And for the reason, education, healthcare, employment. But sometimes I miss Sierra Leone, and I wish to visit. But I'm not homesick per se. Because I don't sit in one place. I travel so

much. The only place I don't go is there. And the only reason because it's so far, and scheduling, you can't get the time in. And you don't go to those regions for one week. It's not possible, so. But, yeah. I mean, I cook. My mom cook. Everything that I can get in Sierra Leone, I can get it here. So, therefore, I mean, that's the reason why I'm not homesick. I want to allow-- right now, I'll go up to the farmer's market. I'll go get the stuff and I'll make it [laughter] you know, so.”

The majority of participants had mixed feelings about leaving Sierra Leone; some were still currently homesick. Some reported that they didn't do much because they were not homesick because of their connection to Sierra Leone within the U.S. Others stated that they called home or engaged in social media, listened to Sierra Leonean music, ate food, or relied on their faith or connection to family.

Emergent Theme: Sierra Leone was Neglected

A general sense that Sierra Leone was a nation that was neglected clearly surfaced from the data as a central and pervasive theme. Across several interviews ($n=10$) there was a general sense that Sierra Leone was neglected because the Ebola epidemic initially wasn't taken seriously by the government of Sierra Leone and the international community until campaigns were created to spread awareness that Ebola cases reached the U.S. Furthermore, this sense of neglect also emerged as participants described accounts of individuals outside of Sierra Leone getting first line treatment, donation funds not reaching the target population due to government corruption in

Sierra Leone along with the delayed response of the health ministry to take adequate precautions to contain the epidemic. Several participants shared their thoughts below:

Brian: “But, like I said, it was still downplayed by the government because they didn't want people to panic or think that the government wasn't prepared to actually handle a viral outbreak such as the EVD. It wasn't taken seriously until we had international help. They came in and they told us what to do, and what not to do, and how to go about it. But if it was left with the Ministry at that time then almost everybody would've died [laughter].”

Marcus: “Yeah, I first heard about it there and made contact with family members in Sierra Leone and got full information of what's happening around the borders to Sierra Leone, Guinea, and Liberia which is the Kono District area which I'm a bit familiar with, and I know how porous it is. So needless to say, it was a frightening effect of how bad it can get into these countries because the borders are not managed properly.”

Tina: “There was more money over the health because when the epidemic did start a little bit, I mean, questions were brought to the health department and people would say, "Oh, something is going on right there in the provinces." And they're like, "Oh, it's just in the provinces. Oh, it's just one person.”

Leo: “I wasn't happy that Americans were not treating this disease seriously, so when there was one outbreak, one person also came in with the pain they started putting it on the news.”

Sarah: “It was a bit funny because I was like, Okay, well, it seems they're not trying to do anything. Now that's in America, they'll probably hurry up and try and help. It's not like it's their war to do something, but at the end of the day they have all the technology. They can help with speeding up research to provide vaccines and stuff. So I was like, probably that will give more attention because, like I said earlier, there wasn't much attention that was given towards a virus until it came outside these countries. Then they were like, "Oh, shoot. This thing can travel.”

Robert: “When Dr. Khan, when he died, that's when it really brought it to my attention like this is serious. Right? So when Dr. Khan died, it was then I really paid attention to it. And actually on his death, that's when situations in Sierra Leone and Liberia started getting worse. Dr. Khan, he was at the Kenema Hospital. He was actually one of the-- there are a number of very popular doctors who succumbed to the virus, but the one that I remember, the more landmark moment most would remember when Dr. Khan died from it. And that's when people was asking, "Whoa. This thing is a little serious?"

Peter: “I think Sierra Leone was neglected because some of these doctors were there. They had no vaccine, no type of prescribed medication by then. But when it happened to an American, they flew that person over here, he was taken in a sealed vehicle, everything was in place. Unlike over there, people were going to help Ebola victims with bare hands. The facilities were not there. So because of that, I thought that even though I'm in America, I saw it,

what the CDC did. And it came to Atlanta, we saw it on television the way they protected the American then I say, I don't know why this would not happen in Sierra Leone. So that's how I felt a little bit neglected, being from a third world.”

Moreover, across several interviews it appeared as if participants felt that the government in Sierra Leone was not equipped to handle the severity of the outbreak and many attributed the spark of the Ebola outbreak in Sierra Leone to research studies that were being conducted at the time. Several participants shared their thoughts below.

Tina: “Nothing was done. Nothing was done. They were notified months. They were notified months. But again, like I said, when you have a non-functioning ministry, and that's why a lot of people thought they were part of the deal to bring it as a biological weapon other than a disease. Because you were so nonchalant to your own people so people started thinking, well you all must have been part of this research. You must have given consent to them to bring-- because I worked research before. I know what happen in research. You have a lot of people here when you do research. There's a lot of consent form for you to sign. There's a lot of process when you go through as a trial candidate and all. Over in Sierra Leone, that's not it. You're basically signing a consent form just for some other researcher to bring back, not a consent form to let you know what--”

Robert: “At the same time, we come to find out that Tulane University was doing research in the Kenema Hospital. And it is public research. And they were researching Ebola, the weaponized Ebola. Tulane University, they had like a huge grant to research weaponized Ebola in the same hospital that the outbreak started. So a lot of controversy on it. But you kind of like step back from the controversy and say, "Okay. How do we address this situation?" But there's definitely a lot of controversy.”

Tania: “The number one way is-- this thing was an experiment, it came as an experiment. Sometimes even for these treaties or experiments and things of that nature, not everyone is good. You know, just like how we watch in the movies. This thing was a contract. I mean, it was an experiment. Most of these experiments, the people they get tested on, most of the time it's always the case where somebody's going to die, and the other person is not. We just want to see if it works on that other person or if it could cure, of it this other person is going to die. So that's what happened and it got spread out.”

Lucas: “Some people have described it as man-made, and some people think it just appears. Nobody really knows where it comes from. It was mentioned that it started at a lab or somewhere around the Mano River union, which is closer to the border of Guinea, Liberia, and Sierra Leone. So since we're now getting word that this is not natural, it was man-made, or it was brought there to be studied up on, so the people that brought it there, what are they doing about it? So, I mean, me personally, I read the document from Tulane

University that mentioned that they were in the region doing study on Lassa fever. And then they stumbled on the Ebola virus as they were doing their research. So, I mean, it just happens that the time that they were there doing that, out of nowhere, there was an outbreak in that region. And there was also rumor, which I don't know what the facts are on that, but the U.S. government and some of these other facilities sponsored some of these local government to build a laboratory that was located within that region where this took place.”

Overall, this sense of neglect along with the various theories and controversies related to what caused the epidemic in Sierra Leone and what prolonged it reveals a sense of disappointment in the political climate within Sierra Leone and the initial international response to a serious and unexpected virus. However, several participants believe that there is still hope for Sierra Leone. With the right leadership, adequate resources, vital partnerships, and the lessons learned from the Ebola epidemic of 2014-2016, Sierra Leone can actualize it's potential. Two participants Brian, age 29, and Robert, age 43, echoed these sentiments.

Brian: “But one thing about the whole Ebola outbreak in Sierra Leone. One thing that we definitely learned is that there's still so much that needs to be done in the healthcare process or management back home. And I'm sure, definitely, if there's another outbreak in Sierra Leone, the government won't take that long much time than it did the last time. A lot of people back home have now been trained on how to do the prevention parts. And how to tackle a

community-based level and also, any treatment process. So I think we might be better equipped to face it in the future.”

Robert: “I’m fully confident that Sierra Leone will rise to the top, certainly to the top. I’m very confident of that. And it’ll take both connecting Sierra Leoneans and Sierra Leoneans in the diaspora. And I believe that once you get all of the energy, resources, and expertise of people who are on the ground and people whom they choose not to go but still have a passionate connection for that we’ll truly realize our potential. But I’m fully confident that Sierra Leone, and Africa as a whole but I can definitely say definitely Sierra Leone, will realize its potential. A lot of people count them out, but Sierra Leone has one thing that most other countries don’t have and that is it’s got the largest young population. And at the end of the day, the future is with the youth.”

Researcher Recommendations

At the conclusion of each interview, all participants were asked “If you had the chance to talk to a group of people who would like to help other immigrants from Sierra Leone what would you like them to know?” The majority of participants reported that they felt Sierra Leone needs help after all it has endured during the Ebola epidemic, during the mudslide, and now with the uncertain political future during the time of elections. Three participants, Peter, age 61, Marcus, age 43, and Francis, age 61, shared their thoughts on others helping Sierra Leone.

Peter: “I would like them to know that that country is a small country with a small population and it needs all the help. Whatever we have there, consider it

as raw materials. They are not in their finished stage. But if this first world can do better by improving the lives, I think things will move in the right direction. Yeah.”

Francis: “I would like them to know that Sierra Leone now is a third world country. But I would like people, whatever they can do to help Sierra Leoneans would be very grateful. We are a third world country, but it sounds as if we're a 10th world country. For a country to be now in the 21st Century with no light, with no electricity, I mean, it's out of this world. And Sierra Leoneans are suffering very much. So if anything people can do to help Sierra Leone, it would be grateful because even us here, we're blessed. We're here. Thank God we're in America. But our thoughts are always in Sierra Leone. Our people, our family members are still there. And you cannot even send enough money to keep them going. So instead of we doing that, if there is any organization that could help Sierra Leone in some of these things, it would also help us here.”

Three participants mentioned that in order to help Sierra Leoneans one must recognize the importance of understanding the people of Sierra Leone and their specific needs by going to the land and learning the culture. Two participants, Tania, age 26, and Sarah, age 29, shared their thoughts on ‘going to the ground.’

Tania: “You have to have patience and you have to have time. You have to be strategical. Don't expect to just go there and get results one time, it has to be an ongoing thing. ... You got to be hands on. Get to know the place. Get to know

the area and field. Most of the people who I do know that want to go there, going fast, or just go there to go get their hands on something. Do not just go there first and just start the project. Go there, get a feel of the place. Get a feel for both cultures. We have many cultures. We have the islands, we have the cities, we have the villages. So get used to everything ... And be open.”

Sarah: “That the approach, when it comes to things happening in Sierra Leone, should be different. You should always try and see the culture of the people first, because Sierra Leoneans are different. They grasp in information differently. And you don't just go and impose on them Sierra Leoneans are the type of people-- they're loving and stuff, but if you go and be boss over their heads, they will not take your advice. You have to make yourself available and be around them so they think we're one. And then when you talk, they listen. When you go and be like, "Oh, because I'm from United States, I have seven masters and five PhDs, and I'm a doctor," they look at you in their snobbish way. Okay, so you have all these-- what's that going to do for me? When you come in, blend with them, even though they know you have all these papers and stuff. Then when you say something, they listen to you, because they know, there's a word in Krio 'rub skin'. You've mingled with them when they sit down to eat and they call you, you eat. You don't be like, "Oh, I don't eat that because I'm from--" So they take you as family.”

The importance of education was also underscored by some participants who reported on the high rate of illiteracy in Sierra Leone. They also mentioned the

importance of specifically educating and empowering young girls and women in Sierra Leone. Two participants, Leo age 32 and Kenneth, age 32, shared their thoughts on providing education in Sierra Leone.

Leo: “For me, education is the key. They must be in school. In my country, the illiteracy rate is so high, so I would tell them about the benefits of education, especially the girl child. They are the most vulnerable people back home.”

Kenneth: “Well, if I had an opportunity to tell them most of this stuff, they need to create series of awareness to our people. The illiteracy in Africa, in Sierra Leone is so high, so they need to embark on so many advocacy group to educate them, to give them awareness. Because mostly in Africa, the women and children when it comes to issues like violence, they are always affected. You have child abuse, sexual harassment, or something like-- they also do it to pregnant women and something. They keep on dying. They keep on-- so obviously this are the areas they need to focus on--like help more women to empower women. Before in Africa, they see women, they're only supposed to be in the kitchen, whereas in America you guys work together.”

Two participants highlighted the importance of not only investing money into Sierra Leone but also investing time to make sure your efforts are reaching the target population. Lucas, age 28, and Tina, age 56, shared their thoughts on investing in Sierra Leone.

Lucas: “Unfortunately, we lack leadership, and we lack professionalism. And if anybody who's thinking about doing something to help Sierra Leone, don't

do it through money. Do it through your time and your experience or your knowledge to transfer into the people. Because I think the more people we can touch, they'll be able to handle situations like this when it comes back. Because, God knows, the government was not prepared for this, and they would never be prepared for this, I hate to say it, because, until this day, even the money and stuff people were sending back to help these people, they still don't account for millions of dollars. And these people, they help their immediate family, and they do whatever they want with this money. So I encourage anybody who's thinking to help Sierra Leone in any way, if you can mobilize and actually go there and do it, do not give money to people who says, "I'm going to do it on behalf of you." If you can go there and do it personally, it will create more impact and it will reach the people who actually need the aid that you're providing.”

Tina: “That they have to be in control of whatever funds and whatever changes at the beginning. They could engage other Sierra Leoneans but when it comes to funds, they have to be in control to make sure that it is reaching the target person. It's reaching the target group. Because you could be away trying to help somebody and you think you're sending funds and it's never getting to them. You think you're helping them and it's never getting to them. That will be my number one that you actually helping the target group, that you're making a difference. You're just not dishing out and not seeing a difference.”

One participant, **Robert**, age 43, highlighted the importance of creating partnerships between the people of Sierra Leone and others within the diaspora. He stated that if people want to help Sierra Leone there should be an exchange of information instead of just providing aid.

“I'm always curious now when there are people wanting to help Africa or help the developing world. The first thing I want to know is like why. Why are they choosing to help? It is more for paternalistic? Like, we need to hold these people's hand who can't walk by themselves or is it more of a partnership? You know what I'm saying? So where is the intention? From my experience, a lot of people who help Africa but it's really a sense of they don't believe these individuals are capable. Right? And so I would just ask, I would want to find out-What are your intentions? Like when you say help, is it more so like a partnership, which is a give and take, where you help each other? Because a lot of folks who-- you have certain expertise but the same time, the African also has expertise that you can exchange. Maybe you are a medical expert or you have expertise in just whatever it is but you realize also that African have expertise in another area. How can we exchange?”

One participant, **Deborah**, age 50, stated that it's important to let others know that Sierra Leoneans are very hospitable and will embrace outsiders. “But people will know because when they go, people are surprised when they go to Africa to see that Africa has a good side. You see, nobody talks about the culture, the good culture.

Nobody talks about the love of foreigners. The kind of welcome we give foreigners in Africa, nowhere else you find that.”

CHAPTER 5

DISCUSSION AND IMPLICATIONS

As existing research on the acculturative experiences of African immigrants in the U.S. is scant (Obasi & Leong, 2010; Orjiako & So, 2014), this study aimed to qualitatively explore the salient acculturative process of an understudied group within the context of a global health epidemic. The interviews yielded rich descriptions of the participants' general knowledge about the Ebola virus disease, their perceived risk for contracting the virus, experiences with Ebola-related stigma, and the impact of this epidemic on their ongoing adjustment within the U.S.

Participants described the Ebola epidemic of 2014-2016 as an unexpected occurrence that created a pervasive sense of worry across the Sierra Leonean diaspora. While the epidemic initially started as a rumor and many questioned the veracity of the reports of those infected, eventually the severity of the epidemic set in as death tolls began to rise and prominent doctors succumbed to the virus. The World Health Organization, noted that when Dr. Sheik Khan, Sierra Leone's only expert on viral hemorrhagic fevers died on July 29, 2014, public doubts about whether Ebola was 'real' were definitely removed (WHO, 2015).

Moreover, many participants highlighted how the Ebola outbreak was only deemed an international emergency once cases reached the U.S. Such sentiments are echoed in an existing research report that highlights how the Ebola epidemic was only declared a 'Public Health Emergency of International Concern' months after hundreds of people died in Liberia, Guinea, and Sierra Leone and the world began to realize that

it was possible for the Ebola virus disease to escape African borders (Karamouzian & Hategekimana, 2014).

Existing research shows that during the 28-month duration of the outbreak, a cumulative total of 28,652 Ebola cases were diagnosed and 11,325 people died from the disease, yielding a case-fatality rate of 39.5 % (Shultz et al., 2016). However, more than 17,300 patients infected with the Ebola virus disease have survived. Within the U.S. there were only four reported cases of the Ebola virus disease and one death. It is clear that the impact of the outbreak was pervasive worldwide as many participants noted. However, given that the actual risk of contracting the Ebola virus in the U.S. was low, the participants' level of perceived risk for contracting the Ebola virus illustrates just how much the fear of Ebola infection was spreading faster than the virus itself (Karamouzian & Hategekimana, 2014; Mitman, 2014).

Given the unknown course of the virus at the time of the epidemic, the limited amount of surveillance within Sierra Leone due to a damaged health infrastructure (WHO, 2015), and some of the participants' probable exposure to the virus through travel, it is safe to say that such heightened fears are plausible. Existing research suggests that fear reactions in response to infectious disease are considered normal and potentially adaptive or protective (Shultz et al., 2016). The fear reactions of the participants influenced them to alter their behaviors in response to the Ebola epidemic and engage in preventative measures that could serve them well in the case of another outbreak. Furthermore, the results of this study underscore the participants' strong and ongoing ties to Sierra Leone within the context of a global emergency. For many of the participants, Sierra Leone is home no matter how many years they have been away.

It is likely that whenever significant historical events impact the nation of Sierra Leone, Sierra Leoneans in the U.S. and throughout the diaspora will also be impacted in some way.

The underlying theme of participants believing that Sierra Leone was a neglected nation vulnerable to the influence of political controversy and misguided research is not a new concept. The participants' ideas about the spark of the Ebola epidemic in Sierra Leone and subsequent mistrust of vaccine developments, mimic remnants of the yellow fever epidemic that occurred in Liberia back in 1926 (Mitman, 2014). At that time it was stated that American medical research greatly profited from the specimens gathered during expeditions in Liberia and led to the 1951 Nobel Peace Prize to Max Theiler for his work on a yellow fever vaccine. However, such research and medical advancements did not contribute to the advancement of medical knowledge and public health capacity within Liberia. Perhaps as the participants of this study reflected on a history of Western exploitation and medical extraction in West Africa, their level of fear during the Ebola epidemic may have been affected (Mitman, 2014).

The results of this study also revealed that participants did experience Ebola-related stigma and differential treatment. Work colleagues made jokes about Ebola, travel plans were significantly delayed, family members and neighbors distanced themselves, and those traveling to the U.S. were forcibly monitored for 21 days. While these precautions were established to contain the spread of this deadly epidemic, it negatively impacted some of the participants as they were targeted and stereotyped simply on the basis of their cultural background.

One would posit that as immigrants already face a number of acculturative stressors upon resettlement in another country (Mena, Padilla, & Maldonado, 1987), Ebola-related stigma would represent another acculturative stressor for Sierra Leoneans in the U.S. While the participants within this study did experience stigma and were treated differently due to their connection to Sierra Leone, it appears as if such experiences did not have a long-term effect on their acculturative process. A large proportion of participants reported they continued to integrate balanced aspects of American and Sierra Leonean culture in their lives or they simply continued to embrace Sierra Leonean culture within the U.S.

While Bhatia and Ram (2009) note that that acculturation is an ongoing, complex and fluid process, the varied experiences of the participants' connection to others and their sense of belonging in the midst of the Ebola outbreak reveals the complexity of the acculturation process. The participants' strong connection to Sierra Leone in the midst of an uncertain political climate coupled with the opportunities they have received in the U.S. seems to have maintained their acculturative statuses as either "integrated" and/or "separated" individuals (Berry, 2003; Bhatia & Ram, 2009; Schwartz et al., 2010). It appears that experiencing Ebola-related stigma did not lead to a change in acculturative status for the study participants. However, when a neighbor who has known you for several years suddenly refuses to let their children play with your children or when coworkers begin to ask you if you've recently traveled to an Ebola-infected zone because of your background, one may wonder if the participants internally questioned their identities as American citizens and residents.

Bhatia and Ram (2009) often note that culture is a ‘positioning’ and the acculturative experiences of immigrants are often shaped by various historical and sociopolitical contexts. The participants and their relative acculturative statuses are not just shaped by the Ebola epidemic of 2014-2016, but rather a combination of experiences that have occurred over time. The civil war in Sierra Leone, the year participants came to the U.S., the mudslide in Sierra Leone, their sense of connection to other American citizens at any given moment, along with the political climates of both Sierra Leone and the U.S. all have the potential to influence how Sierra Leonean immigrants navigate and renegotiate their acculturative identities over time. It is argued that in order to truly understand acculturation one must also understand the contextual factors that influence how individuals enter the acculturation process, what influences their adaptation, and how this process may change over time (Bhatia & Ram, 2009; Cabassa, 2003; Schwartz et al., 2010). Given that there are a number of unknowns regarding the unique cultural contexts of each participant, it may be difficult to pinpoint why some individuals, like the participant Leo, chose to predominately maintain aspects of Sierra Leonean culture in the U.S., while Deborah for example, chose to balance aspects of both Sierra Leonean and American culture even after experiencing Ebola-related stigma and losing American friends.

Additionally, perhaps when participants experienced Ebola-related stigma and modified their behavior by withholding their Sierra Leonean identity in daily conversations, as one participant ‘Patricia’ did, it was to accommodate the social norms of that setting. Even if such behaviors conflicted with deeply ingrained cultural values, such as a great sense of pride in being Sierra Leonean, modifying one’s

behavior in the context of a global health epidemic may be adaptive and can help an individual navigate across cultural boundaries (Molinsky, 2007). Previous research defines the concept of *cross-cultural code-switching* as “the act of purposefully modifying one’s behavior, in a specific interaction in a foreign setting, to accommodate different cultural norms for appropriate behavior” (Molinsky, 2007, p. 623). Perhaps the participants of this study engaged in code-switching to avoid additional experiences of Ebola-related stigma that could threaten their overall positioning within their relative acculturative statuses.

All in all, due to the complexity involved with the acculturative process, it is important to highlight that even as some participants experienced Ebola-related stigma, perhaps there are other factors that helped them mitigate the effects of that acculturative stressor, such as a sense of pride in their Sierra Leonean identity, the drive to succeed in the face of adversity, community connection, or the general hope that conditions will improve for Sierra Leoneans across the diaspora.

Limitations

There are several limitations to address when interpreting the findings of the current study. First, the participants represented a convenience sample and likely represented sub-populations of Sierra Leoneans located in the Washington D.C. and Atlanta metropolitan areas of the U.S. Therefore the findings of this study may not be applicable to the general population of Sierra Leoneans in the U.S. or other immigrant populations who were significantly impacted by this global health emergency.

Furthermore, this qualitative study primarily relied on interview data, memo writing, and demographic information from the participants. Although efforts were made to support the ideals of trustworthiness, a multi-method approach would likely bolster trustworthiness through triangulation.

Future Directions

Given the limited amount of research on the acculturative processes of African immigrants within the U.S., working with these participants has revealed the importance of openly talking to immigrants about their experiences in different countries and sociopolitical contexts to create a clear picture of how complex the acculturation process can be. Findings shed light on the salient issues faced by Sierra Leoneans in the U.S. and throughout the diaspora and also allude to the pervasive impact of global infectious disease epidemics. As mentioned by many of the participants, when working with vulnerable understudied groups, it is important to be flexible, remain open-minded, and follow the cultural guidelines of that population to gain a better understanding of their realities. Essentially this research represented another opportunity for the researcher to ‘go to the ground’ as a partial cultural insider (Cole, 2015) in order to understand the unique triumphs and challenges of Sierra Leoneans within the United States. It is this author’s hope that this study will bring her closer to the shores of Sierra Leone in order to directly make a difference in the lives of Sierra Leoneans after the experiences of war, the Ebola epidemic and the recent natural disaster.

Future studies would benefit from examining the effectiveness of utilizing cultural insiders to conduct ongoing research with understudied populations.

Qualitatively exploring the realities of an understudied group may also serve as a foundation for developing nuanced theories of acculturation on African immigrant populations.

APPENDIX A
Demographic Sheet

Participant code: _____ Date: _____

Please respond to this questionnaire by checking the response that is most descriptive of you. Or please fill in the blank.

1. Gender: () Male () Female
2. Age: _____
3. What ethnic group do you belong to? (Temne, Mende, Kono, Krio, etc.)

4. In which language do you speak most often? _____
5. What is your current relationship status?
 - Single
 - In a relationship
 - Married/Partnered
 - Divorced/Separated
 - Widowed
6. What is the highest level of education you have achieved?
 - 8th grade or less
 - Some high school but did not graduate
 - High School Diploma/GED
 - Trade/technical/vocational training
 - Some college (e.g. one year, associate degree)
 - College degree (e.g. Bachelor's Degree)
 - Graduate degree and/or Professional degree (e.g. MA, MS, and PhD)
7. Are you currently employed?
 - Yes
 - No
- 7a. If yes, what is your current occupation? _____
8. How long have you lived in the U.S.? _____
9. What was your immigration status when you first came to the U.S.?

10. Has your immigration status changed since then? : () No () Yes _____
11. Do you have a primary health physician or access to health care? _____
12. Have you ever received counseling services? _____

APPENDIX B
Interview Guide

[Begin with introduction]

Thank you for agreeing to do this interview. As you know, my name is Daphne Cole and I am completing my Doctoral studies at the University of Rhode Island. I'm very interested in understanding how the recent Ebola outbreak impacted Sierra Leoneans.

Back in March 2014, the first cases of Ebola were found in Guinea. By May it spread to Sierra Leone and by September some cases were found in the U.S. The WHO declared this outbreak as a "Public Health Emergency of International Concern", so I'm interested in your thoughts about this outbreak and if/how it impacted your life.

[Provide information about the interview process, and review informed consent.]

- 1. Please tell me what you know about Ebola?**
- 2. When did you first hear about the Ebola outbreak of 2014?**
- 3. How did you hear about it? (*media (television, newspapers, radio), the internet, general practitioners/doctors, friends and family members, etc.*)**
- 4. Was that a good source of information for you? Did you feel well informed?**
- 5. If you wanted to get good information about Ebola where would you go?**
- 6. When you first heard about the Ebola outbreak were you worried?**
- 7. Do you know anyone that was worried about Ebola?**
- 8. If you think of the recent worldwide situation about Ebola: Did you think that you had a personal risk of acquiring Ebola?**
- 9. When Ebola cases were found in the U.S. what impact did it have on you as a Sierra Leonean?**
- 10. Did you change your behavior because of the Ebola outbreak? (*e.g., avoiding public places/events, travel, use of public transport, and physical contact with others*).**
- 11. Would you take action to prevent contracting the Ebola virus in case of another outbreak? [*In the U.S.? In Sierra Leone?*]**
- 12. Would you be willing to pay for a vaccine that would protect you against contracting the Ebola virus?**
- 13. As a Sierra Leonean, were you treated differently because you come from a country that was impacted by Ebola?**
- 14. Did Ebola-related stigma impact your adjustment and sense of**

belonging where you live? In the U.S.?

- 15. What do you think it means to be a Sierra Leonean in the U.S. today?
Has that meaning changed over time?**
- 16. Since the Ebola outbreak, would you say that you have more African friends, more American friends, or about the same?**
- 17. Have you found it difficult to mix your own family's culture and American culture?**
- 18. Are you actively involved in the Sierra Leonean community or any other community?**
- 19. Since the Ebola outbreak, do you hope to be able to return to Sierra Leone? (*To visit? To live?*)**
- 20. How have you felt about leaving Sierra Leone? [*Explain if participant doesn't understand (relieved, any stress, sadness, anxiety, homesickness, loneliness, frustration, health problems etc.?)*]**
- 21. Do you do anything to help you feel better? (ask only if they describe difficulties)**
- 22. Is there anything else that you would like to share?**
- 23. If you had the chance to talk to a group of people who would like to help other people from Sierra Leone what would you like them to know? [*Reflect and follow up*]**
- 24. Is there anything you would like to ask me?**
- 25. After talking to me today, do you think you would recommend this project to a friend?**

Thank you so much for taking the time to talk to me about your experiences and how to help others from Sierra Leone. Do you have any questions for me?

[Address any questions participants may have and if necessary provide referral information for local mental health provider contact if necessary]

APPENDIX C
Recruitment Flyer



Are you a Sierra Leonean living in the Atlanta or Washington D.C. metro area that....

- ◆ **Is at least 18 years of age?**
- ◆ **Has been living in the United States for at least 6 months?**

If so, you may be eligible to participate in a research study that aims to better understand the experiences of Sierra Leoneans in the U.S. during the 2014-2016 Ebola epidemic. This study is being conducted by Dr. Paul Florin, the lead researcher and Daphne Cole, M.A., a graduate student, from the University of Rhode Island, Clinical Psychology Program, Kingston, RI 02881. This study has been approved by the URI Institutional Review Board (HU1718-061) and the researcher is a first-generation American with Sierra Leonean heritage that is very passionate about this topic.

Participation in this study will involve completing an audiotaped interview lasting about 30 minutes to 1 hour. Your responses to all study questions (see pg. 2) will be kept confidential. At the end of the interview you will receive a \$25 gift card for your participation.

If you are interested in participating please contact the President of *Friends of Sierra Leone*, Peggy Murrah at president@fosalone.org or feel free to directly contact Daphne Cole at 404-964-4605 or djcole@my.uri.edu.

Recruitment Flyer Continued
Interview Questions

- Q1. Please tell me what you know about Ebola?**
- Q2. When did you first hear about the Ebola outbreak of 2014?**
- Q3. How did you hear about it?**
- Q4. Was that a good source of information for you? Did you feel well informed?**
- Q5. If you wanted to get good information about Ebola where would you go?**
- Q6. When you first heard about the Ebola outbreak were you worried?**
- Q7. Do you know anyone that was worried about Ebola?**
- Q8. When you think of the recent worldwide situation about Ebola: Did you think that you had a personal risk of acquiring Ebola?**
- Q9. When Ebola cases were found in the U.S. what impact did it have on you as a Sierra Leonean?**
- Q10. Did you change your behavior because of the Ebola outbreak?**
- Q11. Would you take action to prevent contracting the Ebola virus in case of another outbreak?**
- Q12. Would you be willing to pay for a vaccine that would protect you against contracting the Ebola virus?**
- Q13. As a Sierra Leonean, were you treated differently because you come from a country that was impacted by Ebola?**
- Q14. Did Ebola-related stigma impact your adjustment and sense of belonging where you live? In the U.S.?**
- Q15. What do you think it means to be a Sierra Leonean in the U.S. today? Has that meaning changed over time?**
- Q16. Since the Ebola outbreak, would you say that you have more African friends, more American friends, or about the same?**
- Q17. Have you found it difficult to mix your own family's culture and American culture?**
- Q18. Are you actively involved in the Sierra Leonean community or any other community?**
- Q19. Since the Ebola outbreak, do you hope to be able to return to Sierra Leone?**
- Q20. How have you felt about leaving Sierra Leone?**
- Q21. Do you do anything to help you feel better?**
- Q22. Is there anything else that you would like to share?**
- Q23. If you had the chance to talk to a group of people who would like to help other people from Sierra Leone what would you like them to know?**

APPENDIX D
Recruitment Phone Script



Hello,

My name is Daphne Cole and we met back in June 2014 when I interviewed you about your experiences as a Sierra Leonean in the United States after the civil war. A lot of time has passed since you participated in the study, so I wanted to call and check in with you about the results of the study. Do you have a couple of minutes to speak with me?

Also, if you are interested I can also send you a brief report that outlines the study results.

Study Update:

Twelve men and women participated, aged 25-56, and the study revealed six major themes.

Major themes of results:

- 1. The war was impactful (In Sierra Leone and the U.S)**
- 2. People mainly migrated to U.S. for education, family and to seek other opportunities, only 1 mentioned fleeing the war for safety. People came w/ family or alone.**
- 3. Many people experienced stress when adjusting to U.S. (job, housing, school, cultural differences, stigma, discrimination, conflict w/ AAs)**
- 4. Many people stated that they were impacted psychologically. Some people had reminders of the war and had mixed feelings talking about it. Many people**

stated that they miss Sierra Leone and want to go back to visit or live. Some were disappointed when they came to live in the U.S.

- 5. Many people used faith, family, and resources they had to overcome hardships of war. Faith, family, friends, and a sense of community also helped people adjust to life in U.S. Most said that they gained something by coming to the U.S.**
- 6. Recommendations: All participants recommended going straight to source for information, by directly talking to Sierra Leoneans. They also said a lot of work still needs to be done to help Sierra Leoneans in U.S. and especially in Sierra Leone.**

I'm currently in the process of trying to publish the results of the study in a journal for psychology. Your help was greatly appreciated and can spread awareness about the unique challenges and experiences of Sierra Leoneans.

If participant is eligible continue:

After completing that study, I became interested in following up with you about your experiences in the U.S. during the 2014-2016 Ebola epidemic. Participation in this new study will involve completing an audiotaped interview lasting about 30 minutes to 1 hour. Your responses to all study questions will be kept confidential. At the end of the interview you will receive a \$25 gift card for your participation. I'm in the process of recruiting for this study, so if you are interested in participating feel free to give me a call at 404-964-4605 or email me at Djcole@my.uri.edu.

Thanks again for your time!

APPENDIX E

CONSENT FORM FOR RESEARCH

The University of Rhode Island
Department of Psychology
Address: 10 Chafee Hall, Kingston, RI 02881
Title of Project: The impact of the 2014-2016 Ebola epidemic on Sierra Leonean immigrants in the United States

You have been invited to take part in a research project described below. The researcher will explain the project to you in detail. You should feel free to ask questions. If you have additional questions at later time, please contact Dr. Paul Florin, 401-277-5302, or Daphne Cole, M.A., 404-964-4605, Djcole@my.uri.edu. Daphne Cole, the person responsible for carrying out this study, will discuss them with you. You must be at least 18 years old to participate in this research project.

Description of the project:

The purpose of this study is to better understand the experiences of Sierra Leoneans in the U.S. during the 2014-2016 Ebola epidemic.

What will be done?

If you decide to take part in this study this is what will happen: You will be asked to participate in an interview which will last approximately thirty minutes to an hour and will be audio recorded. You will be asked some questions and can discuss these questions and your answers with the interviewer. All identifying information such as individual names will be removed. In appreciation for your time, you will receive a \$25 gift card after completing the interview. You will receive a phone call 2-5 days after the interview, which will last no longer than 10 minutes. The purpose of this call is to briefly check in with you to see how you are doing and to answer any questions or concerns you may have about the study.

Risks or discomfort:

Answering questions about your experiences during a global emergency can be difficult. If you experience any distress, a list of agencies that have counselors who are experienced working with immigrants will be given to you.

Benefits of this study:

It is possible that you will receive no specific benefits from participating in this study. A potential benefit of this project is to provide a greater understanding of the experiences of Sierra Leoneans who come to the U.S. Some people, however, report feeling relieved to share their experiences with others.

Confidentiality:

Your participation in this study is confidential. Any forms with identifying information, such as this consent form and the follow up contact form, will be kept completely separate from interview materials which will use special codes that are not linked to your name. You will also be asked to choose a pseudonym, or false name, at the beginning of the interview and that name will be used on the audio recording. To keep your information confidential, the audio recording of the interview will be placed in a locked file cabinet until a written word-for-word copy of the interview has been created. All typed versions of interviews will be kept on a computer that is password-protected and uses special coding to protect confidential information. All study materials will be destroyed three years after the completion of this study.

Decision to quit at any time:

The decision to take part in this study is up to you. You do not have to participate. If you decide to take part in the study, you may quit at any time without penalty. If you wish to quit, simply inform Daphne Cole of your decision during the interview or by calling her at 404-964-4605.

Rights and Complaints:

If you are not satisfied with the way this study is performed, you may discuss your complaints with Dr. Paul Florin, 401-277-5302 or with Daphne Cole, 404-964-4605, anonymously, if you choose. In addition, if you have questions about your rights as a research participant, you may contact the office of the Vice President for Research and Economic Development, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

You have read the Consent Form. Your questions have been answered. Your signature on this form means that you understand the information and you agree to participate in this study.

Signature of Participant

Signature of Researcher

Typed/printed Name

Typed/printed name

Date

Date

The researcher will use a digital recording device in order to audio record the full interview between the participant and the researcher. Please indicate your decision to be recorded by placing an "X" on one of the lines below followed by your signature.

I agree _____ or I decline _____ to be recorded

Signature of Participant

Are you interested in participating in future research studies focused on the experiences of Sierra Leoneans?

Please indicate your decision by placing an “X” on one of the lines below followed by your signature.

I agree_____ or I decline_____ to be contacted for future research studies.

Signature of Participant

Please sign both consent forms, keeping one copy for yourself.

APPENDIX F

Support Agencies- ATLANTA, GA METRO AREA

1. Georgia State University Psychology Clinic

The Psychology Clinic is the primary training site for Georgia State University's graduate program in clinical psychology. The Clinic offers high quality and affordable psychological services to adults, children, adolescents, families and couples from the greater Atlanta area. Counseling and assessment services are provided by doctoral graduate students supervised by licensed psychologists. The Clinic provides low cost services to adults of all ages. Therapy is offered for a range of mental health concerns.

Website: <http://psychologyclinic.gsu.edu/>
140 Decatur St SE #1053,
Atlanta, GA 30303
404-413-6229.

2. A Healing Paradigm, LLC

This agency offers a collaboration of wellness focused practitioners who take a holistic approach toward healing. They apply complementary therapy approaches and techniques. These providers are passionate about counseling persons of African descent, offer services for a range of mental health concerns, and focus on integrating indigenous healing practices into psychotherapy. Therapy services may be covered in full or in part by your health insurance or employee benefit plan.

Executive Director: Ifetayo Ojelade, PhD
Website: <http://www.ahealingparadigm.com/index.html>
867 Harvard Avenue
College Park, GA 30337
404-635-6021

3. Metropolitan Counseling Services

This is a non-profit organization dedicated to providing quality, affordable counseling and psychotherapy to adults in the Metropolitan Atlanta area who otherwise could not afford such services. MCS offers individual, couples, and group psychotherapy in a warm, safe and supportive environment on a low-cost, sliding-scale fee. Services are offered for a wide variety of mental health concerns.

Website: <https://mcsatlanta.org/>
2801 Buford Hwy
Atlanta, GA 30329
404-321-1794

4. Catholic Charities Atlanta

This agency is a faith-based not-for-profit that helps families and individuals in north Georgia transition from adversity to self-sufficiency. We provide access to accredited social services that meet specific needs, and do so with respect and compassion.

Website: www.catholiccharitiesatlanta.org
680 West Peachtree Street, NW
Atlanta, GA 30308
404-881-6271

5. Center for Victims of Torture – Atlanta

This is a non-governmental human rights organization committed to healing the wounds of torture and stopping torture worldwide. We rebuild lives by providing healing services to survivors of political torture and their families. Our staff has extensive training and experience in providing culturally competent services within an inter-disciplinary model. Our Atlanta clinic provides psychotherapy, social services, and care coordination at no cost to qualified clients.

Website: [www.cvt.org/ where-we-work/Georgia](http://www.cvt.org/where-we-work/Georgia)
2295 Parklake Dr., Suite 434
Atlanta, GA 30345
470-545-2776

6. Access Mental Health

This agency provides a range of community-based services ranging from individual and group counseling, behavioral health assessments, crisis intervention, psychological testing, nursing, pharmacy and lab services, and community support. Licensed therapists provide a range of therapeutic intervention services for a variety of mental health concerns.

Website: <http://www.access-mha.com/>
215 Lakewood Way, SW
Suite #205
Atlanta, GA 30315
678-335-9010

7. Heartwork Counseling Center

This agency offers in depth-oriented psychotherapy to the Atlanta community. Counselors provide skillful, confidential, and professional services in a relaxed private practice setting where every individual is regarded with personal consideration and respect.

Website: <http://www.htwcc.org/>
990 Edgewood Ave NE,
Atlanta, GA 30307
404-658-1222

Support Agencies- WASHINGTON D.C. METRO AREA

1. **African Immigrant & Refugee Foundation (AIRF) Mental Health Program.**

This organization uses a network of African-born mental health professionals to provide assessments and counseling that is linguistically and culturally appropriate for each client. Counseling uses a traditional African framework based on age group, gender and extended family groups.

- 11350 Baroque Road
Silver Spring, MD 20901
301-593-0241

Website: <http://www.airfound.org/>

2. **Community Connections**

This organization is the largest private, non-profit provider of behavioral health, residential services, and primary health care coordination for communities in the District of Columbia who are coping with mental illness, addiction, and the aftermath of trauma and abuse.

- 801 Pennsylvania Ave SE, #201
Washington, DC 20003
202-608-4798

Website: <http://www.ccdc1.org/>

3. **Catholic Charities: Archdiocese of Washington**

This organization is the social ministry outreach agency that houses a number of services to refugee and immigrant populations. The Refugee Center offers case management and employment service support to recent refugees and asylum seeker living in DC as they seek to make a new start in the US. Assistance is offered in job searching, interviewing, benefit enrollment, workplace ESL classes, immigration legal services and all facets of the employment process. Main Telephone : (202) 529-2991

Website: <http://www.catholiccharitiesdc.org/RefugeeCenter>

There are several locations listed below.

1618 Monroe Street, NE
Washington, DC 20017
202-939-2420

924 G St., NW
Washington, DC 20001
202-772-4352

12247 Georgia Ave.
Silver Spring, MD 20902
301-942-1790

201 E. Diamond Ave., 3rd Floor
Gaithersburg, MD 20877
301-740-2523.

4. **Torture Abolition and Survivors Support Coalition (TASSC):**

TASSC is a non-profit organization that provides a range of support services for survivors of torture such as free counseling, free housing on a temporary basis, free legal representation for those who are seeking asylum, medical referrals, employment related assistance and other services.

- Website: <http://www.tassc.org/counseling>
4121 Harewood Road, NE, Suite B, Washington DC 20017,
Telephone: 202-529-2991

5. **Advocates for Survivors of Trauma (ASTT):**

This organization is a part of the National Consortium of Torture Treatment Centers, a network of service providers who specialize in the care of torture survivors. It provides free psychological and case management services in order to address survivor's needs in a culturally responsive and holistic way.

- Baltimore Office: 431 East Belvedere Avenue
Baltimore, MD 21212
Telephone: 410-464-9006
- Washington DC Office
1624 U Street NW
Washington, DC 20009
Telephone: 202-290-1672
Website: <http://astt.org/wordpress/>

6. **Human Rights First:**

This organization is an independent advocacy and action organization that offers a Refugee Protection Program is that committed to advancing the rights of refugees, including the right to seek asylum. This agency advocates for access to asylum, for fair asylum procedures, and for U.S. compliance with international refugee and human rights law. Legal services are offered to refugees through a pro bono Asylum Legal Representation Program.

- Washington DC Office
805 15th Street, NW
Suite 900
Washington, DC 20005
Telephone: 202-547-5692
Website: <http://www.humanrightsfirst.org/our-work/refugee-protection>

7. **The Washington Pastoral Counseling Service**

This is an interfaith, non-profit organization with a mission of providing low-cost mental health services to children, individuals, couples and families in the DC metropolitan area. Counselors work with children and adults struggling with a range of issues including early childhood trauma, separation and divorce, spouse abuse and battering, depression, behavioral and substance addictions, communication skill deficits, grief and abuse recovery.

- 9727 Georgia Avenue
Silver Spring, MD 20910
301-681-3201

APPENDIX G
Follow-up Contact Form

Thank you so much again for the taking the time to talk with me about your experiences. We have discussed many topics today and I would like to briefly follow up with you in a few days just to see how you are doing and to answer any additional questions you may have.

Please provide your contact information below:

Name: _____

Telephone #: _____

Best time to reach you: _____

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