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Walden University

College of Health Sciences and Public Policy

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Mary Nganga

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Dr. Amber Dessellier, Committee Member, Public Health Faculty
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Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2022

Abstract

Impact of Religion on Mental Health Care Use Among African Immigrants in the United States

by

Mary Nganga

MS, Azusa Pacific University, 2015

BS, Azusa Pacific University, 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

November 2022

Abstract

Mental health illnesses are the leading causes of disability worldwide with one in every five people suffering from mental illness in the United States. African Immigrants are the fastest growing immigrant group in the United States, yet their mental health care use remains relatively low. African immigrants face stressors that may lead them to be more prone to mental illness, yet they depend on religion and family support rather than formal mental health care. The purpose of this qualitative study was to understand the impact of religion on mental health care use among African immigrants in the United States. The theory of planned behavior provided the framework for the study. Data were collected from 10 African immigrant participants living in the United States using semistructured interviews. Thematic analysis was used with a deductive approach to gain perception of the data. There were three emerging themes from the study: perception of mental illness, treatment of mental illness, and the role of religion in mental illness. The study findings noted that religion was a barrier to mental health care use due to the heavy cultural and religious associations African immigrants had in the interpretation of mental illness. The results can be used to increase cultural competence among healthcare providers regarding mental illness and African immigrants as well as promote collaboration between healthcare and African religious sectors in the United States. The study contributes to a positive social change by providing information such as increased awareness and cultural sensitivity, that can be used to improve mental health care among African immigrants in the United States.

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Dedication

To my handsome boys, Ryan, and Jeremy, never stop learning, defy all statistics, and break all limitations.

Love, Mom

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Betty Mbithe, you are a true friend who has been such a support. This success is as much mine as it is yours. I love and cherish you. God bless you.

Pastor, Dr. Phinehas, thank you for teaching me to dream, become, be better, and repurpose my pain. I am grateful

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Chapter 1: Introduction to the Study

Mental health illnesses are the leading causes of disability worldwide (Anxiety and Depression Association of America [ADAA], 2020). One in every five adults suffers mental illness every year in the United States (National Alliance of Mental Illness [NAMI], 2021). The World Health Organization (WHO, 2020) reported that worldwide almost 75% of people with mental health problems remain untreated, contributing to suicides, more disability, and overall poor quality of life. African immigrants in the United States are the fastest-growing immigrant group, which has continued to double every decade since 1970 (Omenka et al., 2020; Tamir, 2022; U.S. Census Bureau, 2020). In 1980, there were 816,000 African immigrants in the United States compared to 4.2 million in 2016 (Tamir, 2022). Despite being more likely to have health insurance than immigrants from other countries and being more highly educated than American-born citizens, their mental health care use remains relatively low with reliance on family support and religion rather than medical care (Adu-Boahene et al., 2017; Anderson, 2017; Derr, 2016; Echeverria-Estrada & Batalova, 2019; Omenka et al., 2020).

Adu-Boahene et al. (2017) reported that underuse of mental health services is significantly more prevalent among immigrants residing in the United States for periods less than 10 years. African immigrants are more prone to mental disorders as they try to assimilate and acculturate to the dominant culture, face discrimination, and experience language barriers (Omenka et al., 2020). Immigrants from war-torn countries are at greater risk for mental disorders as they seek asylum in their new countries while severing all ties with their countries of origin (Adu-Boahene, 2017).

Mental health care is paramount to ensure health and wellness. The low levels of mental health literacy and high levels of mistrust, apprehension, and stigma experienced by African immigrants in the United States contributes to the underusage of formal mental health care by this population (American Psychiatric Association [APA], 2017; American Foundation for Suicide Prevention [AFSP], 2019; Mental Health America [MHA], 2020; WHO, 2020). Religion, which includes traditional faith and values, serves as the cornerstone of wellness among the Black population in the United States which includes African immigrants (AFSP, 2019; Wharton et al., 2018). There is a higher reliance on cultural avenues and spirituality for overall wellbeing as well among African immigrants (Omenka et al., 2020; NAMI, 2020). Understanding the role of religion in mental health care use is consequently paramount to better comprehend and collaborate mental health care for African immigrants in the United States

In this chapter, I will cover the background of this study, present the problem statement, describe the purpose of the study, state the research questions, describe how the theoretical framework will be used, define the nature of the study, describe the assumptions, scope, delimitations, and limitations, and finally present the significance of the study.

Background

African immigration to the United States began in 1600 from forced immigration due to slavery and has continued into voluntary immigration as world globalization occurs (Tamir, 2022). There has been a 71% increase in the United States African immigrant population since 2000, making one in every 10 Black persons living in the

United States foreign born. The top five African countries contributing to the migration are Nigeria, Ethiopia, Egypt, Ghana, and Kenya, accounting for more than half of foreign-born Africans in the United States (Anderson, 2017; U.S. Census Bureau, 2020). West African immigrants make up about 44% of African immigrants to the United States immigrants, with East African's making up 36% of this population with the remaining countries contributing from the south and Northern Africa (U.S. Census Bureau, 2020).

Sackey-Ansah (2020) reported that the emigration of African immigrants to the United States results from various push-pull factors. The push factors providing Africans momentum to leave their native countries include political unrest, economic hardships, inflation, or recession. In contrast, the pull factors encourage Africans to emigrate to the United States, such as higher education, better opportunities, and dream actualization (Sackey-Ansah, 2020). Most of the immigration from Africa is voluntary from reunification to their relatives in the United States, attaining higher education, increased globalization to higher-income countries, and diversity visa programs (Commodore-Mensah et al., 2018; Echeverria-Estrada, & Batalova, 2019; Tamir, 2022).

Compared to other immigrant groups in the United States, African immigrants are more likely to have higher education with bachelor's degrees or higher and be English-speaking at home with a middle-class socioeconomic status (Tamir, 2022). However, Tamir (2022) noted differences in education and income depending on country of origin, with Nigerian and Kenyan immigrants being more likely to have a bachelor's or master's degree and fall in middle to high-income categories while Somalians and Ethiopians are less likely to be educated. Education levels of immigrants are also noted to be dependent

on the political stability of the country of origin, with refugees from politically unstable countries being less likely to be educated and consequently having a lower socioeconomic status (Tamir, 2022). African immigrants tend to settle in larger metropolitan areas, with more than one third of all African immigrants to the United States. residing in New York City, Washington, DC, Dallas, Minneapolis, or Atlanta (Covington-Ward et al., 2018; Echeverria-Estrada & Batalova, 2019; Omenka et al., 2020; Tamir, 2022).

Problem Statement

Previous and current literature shows that it is paramount to have more research among African immigrants in the United States as it is the fastest-growing group of immigrants in the United States (see Adekeye, 2014; Agbemenu, 2016; Ekwonye et al., 2021; Freeland et al., 2020; Nantwi et al. 2017; Omenka et al., 2020; Shoup et al., 2021; Venters et al., 2011). Still, few studies have been conducted to understand the specific health needs of African immigrants. Mental illness is especially crucial as it is the highest cause of disability among the 18-65 age group and has detrimental effects on the economy with the loss of workforce and wages (WHO, 2020). Delayed seeking of mental health services is also associated with increased chronicity and severity of mental illness, which therefore results in use of emergency care rather than preventative and maintenance measures, which are less costly and more effective (MHA, 2020).

Health needs among African immigrants remain under researched as few studies are done among African immigrants, and studies done among Black people in the United States do not differentiate between African immigrants, Caribbean immigrants, or

African Americans (MHA, 2020; Pew Research, 2022). There is thus a lack of knowledge about African immigrants' health needs (Venters et al., 2011). Venters et al. (2011) noted that despite mental illness being the top three diagnoses identified among African immigrants, referral to mental health services remains unused or even suggested by health care providers. As such, the issue with the underuse of mental illness care is multifocal.

Religion cannot be understated in its role among African immigrants and their wellness. Multiple authors have noted that religion has a role in healthcare use, but the specific role is not clearly described (see Adekeye, 2014; Agbemenu, 2016; Ekwonye et al., 2021; Freeland et al., 2020; Nantwi et al., 2017; Shoup et al., 2020). Understanding how religion impacts decisions about mental health care use can help identify and attempt to meet the needs of the fastest-growing immigrant group in the United States.

Purpose of the Study

In this study, I built on available literature and provide a qualitative exploration of how religion impacts mental health care use among African immigrants in the United States. In understanding the social problem from the immigrant's perspective, information can further inform clinical care through cultural competence to reduce disparities that immigrants face and thus improve quality of life. The purpose of this qualitative study was to understand the experiences of African immigrants in the United States with the mental health system and how religion influences mental health care use among this population.

Research Questions

RQ1: What are the experiences of African immigrants in the United States with mental health care use?

RQ2: How does religion influence mental health care use among African immigrants in the United States?

Theoretical Framework

Ajzen (1985) developed the theory of planned behavior (TPB) to describe and predict behaviors. The theory is a refinement of the theory of reasoned action by Ajzen and Fishbein (Boslaugh, 2019). In TPB it is assumed that behaviors are under a person's will, and hence the theorists seek to understand the relationship between human behavior and motivation (Boslaugh, 2019). The TPB indicates that attitude towards behavior, perceived behavioral control, and subjective norms are the main themes that influence behavior patterns (Asare, 2015; Tornikoski & Maalaoui, 2019; Vaismoradi et al., 2016). Using the themes of TPB allows a researcher to conduct thematic analysis for both latent and manifest content, with coding being completed through probable subthemes. Behavioral intention is the motivational factor influencing behavior; the more robust the intention, the more likely the behavior's engagement (Asare, 2015).

The attitudes towards behavior are the favorable or unfavorable appraisal from the behavior. Attitudes are comprised of behavioral beliefs and outcome evaluations (Asare, 2015). If the appraisal is unfavorable, then engagement would be unlikely in the behavior. Understanding the behavioral beliefs of African immigrants in the church and the appraisal results towards health-seeking behaviors may increase cultural competence,

which increases collaboration between religion and the medical providers (Asare, 2015). The subjective norm is the social pressure to perform or not to perform a specific behavior. This construct is vital in immigrant societies due to the value of community support and religion for total wellbeing, which can influence seeking or not seeking formal mental health care (Asare, 2015; Agbemenu, 2016). Behavioral control is the ease or difficulty of performing behavior that can be used in religious settings by removing barriers such as stigma that increase the difficulty of medical seeking behaviors (Asare, 2015; Nantwi et al., 2017; Omenka et al., 2020; Vaismoradi et al., 2016)

Nature of the Study

To address the research questions, I employed an ethnographic qualitative design using semistructured interviews and field notes for data collection. This design yielded descriptive qualitative data to further improve an understanding of the role of religion in mental health care use among African immigrants in the United States. Qualitative research is an iterative process that allows a deeper understanding of a community through proximity (Aspers & Corte, 2019). Ethnographic studies offer a comprehensive understanding of cultural groups within a people group allowing the reader to understand the culture group characteristics such as religion among African immigrants (Morgan-Trimmer &Wood, 2016).

Semistructured interviews allowed for the integration of both structured questionings on interviews and allow the researcher to probe deeper in pursuit of detailed responses. The flexibility is thus an added merit to the study design as new ideas can be obtained that were not previously thought of (DeJonckheere & Vaughn, 2019). Individual

interviews may also allow the divulging of information from participants without worrying about stigma or how others would perceive them, which is an essential and crucial element as the underutilization of mental health care among African immigrants has been partially attributed to cultural stigma issues (MHA, 2020; Omenka et al., 2020). The fundamental concepts of and the phenomenon of the investigation was religion among African immigrants in the United States.

I collected the data from African immigrants of using semistructured interviews. The study was limited to the greater Houston metropolitan area. Nonprobability purposeful and snowball sampling strategies were used with recruitment taking place in places of worship and restaurants that serve African immigrant communities in the Houston area. Ten interviews were conducted, and data saturation was reached. Interviews took place in the conference room of a local library as well as through Zoom. Field notes and audio record were taken on each of the interviews. Zoom was used for transcription while Dedoose software was used for coding and assistance with analysis. All data was stored in my personal computer, which was password protected to ensure no unauthorized persons could have access. Analytic induction and thematic analysis were used for data analysis to identify emerging themes related to the experiences of African immigrants with the mental health system and the ways in which religion affects mental health use among the African immigrants sampled (see Braun & Clarke, 2014).

Definitions

African immigrants: People born on the African continent who have immigrated into the United States for permanent residence (Tamir, 2022).

African traditional religions: Systems of faith in worship of ancestors, mountains, higher powers such as witchcraft, sorcery, and the dead (Nantwi et al., 2017; Omenka et al., 2021).

Coping: Enduring and adjusting with unpleasant outcomes, such as mental diseases, to defeat and deal with the events (Omenka et al., 2021; WHO, 2020).

Disability: A condition that causes impairment to the recipient making it difficult to work or interact with normalcy with the rest of the population (Centers for Disease Control and Prevention, 2021).

Formal mental health care: The use of a health provider for the services of mental health illness and following through with instructions or treatment provided (Wharton et al., 2018).

Health providers: Members of the health system that provide care to patients such as nurses, nurse practitioners, doctors, therapists, and psychiatrists.

Informal mental health care: The use of friends, family, or religion to help cope with mental illness.

Mental health care use: The use of formal health care systems and resources for health such as hospitals, clinics, psychiatric rehabilitation, psychiatrists, therapists, psychologist, doctors, or nurses for mental health issues (Omenka et al., 2021).

Mental health literacy: The knowledge and understanding of mental disorders that aid in easy recognition of the disorders to foster treatment and prevention.

Mental illnesses: Collective term of diseases affecting mental and cognitive health such as depression, anxiety, psychosis, dementia, and schizophrenia (MHA, 2020).

Religion: Systems of faith and belief in the worship of a higher being such as God (Wharton et al., 2018).

Religious leaders: Leaders of various religious entities such as priests, clergy, traditional leaders, elders, and Imams.

Assumptions

Assumptions in the study are aspects I assumed to be true. I assumed that participants would be forthright in sharing their experiences and would engage with me to answer the questions in an in-depth manner. Their honest and truthful opinion was also expected. Another assumption was that African immigrants would have similar experiences in the immigration process. Their experiences of immigration and relocation were also assumed to be relatively similar in this study. The assumptions were necessary for the study because I desired to gain a deeper understanding of the participant's experiences of the role of religion in their lives and cultures in influencing mental health care use, to make correct inferences.

Scope and Delimitations

The scope of the study was limited to African immigrants who were currently living in the United States. The range of delimitations were African immigrant residents in the United States, with a religious preference. The study was limited to adults 18 years

and older. The study excluded those below 18 years. All participation was voluntary, and all participants were provided with informed consent. The study investigated African immigrants' experiences as it related to mental health care use in the United States but did not include direct observation. Instead, I relied on participants descriptions of their experiences in their own words.

Limitations

The study sample was small so generalization to all African immigrants in the United States was not assumed. The fear and stigma associated with mental illness among African immigrants could also have generated false information to me from fear of disclosing personal or family experiences with mental illness. The design use of semistructured interviews may have also been a limitation with participants who did not feel comfortable divulging more in-depth information to me. Biases associated with purposive sampling such as selection bias may have been possible as all participants of the study had the defined characteristics to fit the study. Consequently, there was a lack of random sampling that avoided similar possible characteristics in demographics, religious experiences, family dynamics and history of their backgrounds.

To address these the limitations, I used semistructured interviews to probe for further information from the participants if the information provided was unclear or too generalized; thus, the provision of detailed information was likely more accurate. Use of purposeful silence was used to allow the participants to divulge more information (see Bengtsson & Fynbo, 2018). To enhance comfort in disclosing information, interviews were more informal with some general questions before easing into the actual questions.

Questions were also conversational rather than standardized to avoid the perception of a formal interview and to ease anxiety (see Aspers & Corte, 2019). This required me to familiarize myself with the questions and avoid excessive writing during the interview to pay attention to the interviewee. The biases in purposive sampling were combated by a clearly defined target population and sampling frame from which the group of participants was drawn (see Andrade, 2021)

Significance

Information gained from this study may be used to equip religious leaders and health care providers with the knowledge needed to foster mental healthcare use among African immigrants to the United States. Increasing mental health care use fosters improved mental health outcomes and wellness thus contributing to positive social change among African immigrants in the United States (MHA,2020). Gained knowledge from the study increases available data on African immigrants in the United States, which can foster an increase in cultural competency among providers dealing with an ever-diverse population. The information gained from the study may also be used to integrate cultural competence in clinical practice regarding African immigrants in the United States which then adds to the scant data available for providers on African immigrants which would advance available knowledge for referencing.

The information gained may be used to develop cultural competence trainings for mental health providers working with African immigrants therefore improving mental health wellness among African immigrants in the United States. The study information may also be used to increase collaboration between religious institutions and healthcare

providers to provide holistic care to African immigrants. This study is also significant in that the information deducted may be used to inform positive social change by guiding policymakers and clinicians in not only cultural competence in the treatment of African immigrants but also the importance of including religiosity in the treatment plans which is beneficial for African immigrant mental health and wellness.

Summary

African immigrants are the fastest-growing immigrant group in United States. Black Americans continue to use mental health care at lower rates compared to other races with high reliance on religion though how religion impacts their mental health wellness remains unclear (Omenka et al., 2020). Mental illness is the highest contributor of disabilities among middle-aged adults worldwide with economic, productivity, and quality of life ramifications (MHA, 2020; WHO, 2020). Despite studies conducted with other immigrant groups in relation to mental health care use, there is scant data on African immigrants' mental health. This study may provide a greater understanding of how religion influences mental health care use among African immigrants. The information gained from this study will not only contribute to literature available on African immigrants' mental health but also provide collaborative ways in which both religious institutions and health providers can use the knowledge to provide holistic mental health care to African immigrants to improve their mental health outcomes. Chapter 2 will provide a review of the relevant recent literature on this topic, discuss the relevance of the TPB to the study as well as describing how the theory was used in the study.

Chapter 2: Literature Review

Mental illness remains the leading cause of disability worldwide, with one in every five adults having suffered a mental illness in the United States (ADAA, 2020; NAMI, 2021; WHO, 2020). Mental health care use remains low, with WHO (2020) reporting that 75% of people who have mental illness remain undiagnosed and untreated. African immigrants in the United States have lower mental health care use despite having health insurance and having higher education which indicates the need to understand the experiences that affect health care use (Omenka et al., 2020; Shoupe et al., 2020).

Religion among African immigrants is fundamental, with Ajima and Ubana (2018) attributing the health and wholeness of Africans to their religious beliefs and practices. Despite data showing the social problem of underuse of mental health services among African immigrants in the United States and studies indicating that religion plays a role, the ways and extent of religion's role in mental health care underutilization is not fully understood. In addition, most data is from studies of West African immigrants to the United States, with scant data on immigrants from other African countries. As such I examined the role of religion among African immigrants in the United States by recruiting a wide variation of African immigrants for the study. This chapter will include a description of the literature search strategy, the study's theoretical foundation, a review of the literature related to critical variables and concepts of the study, and a summary/conclusion.

Literature Search Strategies

Peer-reviewed journals, scholarly articles, and nationally recognized sources were used in an iterative process to gather information for the literature review. The keywords used in the searches were *African immigrants in the United States, mental health/mental disorders/psychiatric illness, mental health care use,* and *religion/spirituality/faith* used interchangeably in databases to provide results. Combined search terms included *African immigrants in the United States and mental health; African immigrants in the United States and religion; role of religion among immigrants in the United States; Blacks, religion, and mental health; spirituality among African immigrants and health-seeking behaviors; stigma among African immigrants on mental health;* and *the role of the church and mental health among Blacks*. The databases used were MEDLINE, CINHAL, PsychINFO, PubMed, Science Direct, EBSCO, ProQuest dissertations, and Google Scholar. A combination of search terms was used to provide relevant journals. Results were limited to peer-reviewed journal articles published between 2016 and 2021.

Literature Review Related to Critical Variables and Concepts

Religion is essential in the larger Black community in the United States, including African Americans, African immigrants, Caribbean immigrants, et cetera, with more than 90% attributing wholeness and wellness to religious aspects (MHA, 2020; Tamir 2022). The role of region among African immigrants cannot be underestimated. A review of the literature related to critical variables and concepts of the study which included a deeper understanding of religion, Mental illness and acculturation was hence discussed.

Religion

Sackey-Ansah (2020) and Omenka et al. (2020) viewed religion as any belief in higher power through organized institutions such as Catholicism, Christianity, Islam, or traditional indigenous belief systems among African immigrants. In multiple studies among blacks in the United States in which African immigrants are included, wholeness and wellness are attributed to religion and right standing with God, thus affecting all facets of life (Ekwonye et al., 2021; MHA, 2020; Nantwi et al., 2017; Omenka et al., 2020; Saasa, 2019; Ting & Panchanadeswaran, 2016; Wharton et al., 2018). Various facets of religion such as focus of life, coping, social support, wellness, and role of religious leaders are discussed.

Religious Participation as the Focus of Life

Spirituality and religion have been used synonymously by Ting and Panchanadeswaran (2016) as playing a role in an individual defining their meaning of life. In a qualitative phenomenological study using semistructured interviews of 15 African Immigrant women from five different African countries who are now residing in the United States, findings note that when faced with stressful situations, African immigrant women choose the lens of religion to understand their circumstances and make decisions pertaining their families in cases of domestic partner violence (Ting & Panchanadeswaran, 2016). The study sought to understand African immigrant women's perceptions of faith-based leaders in Islam and Christianity after partner violence. The results indicated feelings of being blamed, stigmatized, misunderstood, and lack of actual practical help, such as women's shelters were noted (Ting & Panchanadeswaran, 2016).

The study findings demonstrated that although religious institutions were the first line of help among African immigrants in stressful situations, its role is not clearly defined as beneficial for the women as results concluded hesitancy in seeking care due to the findings of blame, stigmatization, and being misunderstood (Ting & Panchanadeswaran (2016).

Like the findings of Ting and Panchanadeswaran (2016), Nantwi et al. (2017), in a qualitative exploratory research study of African immigrant college student's perceived identities (*N*=13), found that religion broadly frames their identity as African immigrants in the United States by affecting their decision making. This was noted by constantly referencing religion as their influencer in making decisions. Religion also influences how they interact in their colleges by seeking like-minded individuals with similar beliefs and health behaviors such as smoking or drinking (Nantwi et al., 2017). Religion thus plays a role in their health-seeking behavior and use of health care services behaviors though the extent of the role is not fully portrayed. Sackey-Ansah (2020), in a scoping review of primary studies done on African immigrants, finds that religion is deeply ingrained among African immigrants in decision making and view of life and thus that it is inseparable from who they are which are similar findings as those of Nantwi et al., (2017). The study findings reported that the profoundly ingrained spiritual roots frame African immigrants' perceptions of health and health-seeking behavior, which consequently alludes to studying how religion frames the mental health care use among African immigrants in the United States (Sackey-Ansah, 2020).

Religion and Social Support

Religion among African immigrants does not only refer to spiritual practices such as prayer or attendance to a religious institution but also the social aspect of providing a support system and opportunities of social belonging among African immigrants (Ekwonye et al., 2021; Omenka et al., 2020). Omenka et al. (2020), in a scoping review of data of African immigrants in the United States from 1980 to 2016, using an open coding approach, found that religion was not only viewed as relevance to God but also a sense of belonging to the community. Immigrants not affiliated with churches or mosques thus reported feeling alone and isolated (Omenka et al., 2020). Omenka et al. also found that more than 90% of the scholarly journals reviewed noted religion as a source of physical/spiritual wholeness and source of support. Support and social belonging are essential in mental wellness since lack of support are attributed to poorer health outcomes (MHA, 2020). As such, religious support among African immigrants is essential in improving health outcomes.

Similarly, in an exploratory qualitative study examining the meaning of life and the impact of COVID-19 on African immigrants in the United States, Ekwonye et al. (2021) found that most participants reported that their informal relationships were mainly formed in religious settings. The reduced face to face interactions led to feelings of social isolation, anxiety, and lack of social satisfaction during the COVID -19 closing of public gatherings (Ekwonye et al., 2021). The social isolation from lack of religious gatherings and in-person meetings with friends and relatives contributed to overall feelings of situational depression and anxiety among the study participants (Ekwonye et al., 2021).

Social support is thus essential among African immigrants as it provides a means of belonging and coping in their new environments.

Religion and Coping

Religion aids in coping with various hardships such as discrimination among African immigrants in the United States (Ekwonye et al., 2021; Nantwi et al., 2017; Nguyen, 2020; Omenka et al., 2020). Religious affiliation is strongly associated with coping (Saasa, 2019). In a largescale cross-sectional survey involving 409 African immigrants in 42 out of 50 states, religion was found to serve as a buffer to discrimination despite not offering moderation effects (Saasa, 2019). Passive religious coping was found to exacerbate adverse effects and led to more isolation, deprivation, underemployment, despite the higher levels of human capita among African immigrants (Saasa, 2019). Among the participants use of active coping, defined in this study as the use of formal health care, counseling, integration with American communities, and moderation, was noted to reduce the effects of discrimination among the African immigrants.

The same phenomenon is noted by the findings of Agyekum and Newbold (2016) through an exploratory study of religious leaders, health practitioners, local group leaders, and immigration counselors. Findings were that places of worship are essential to social, spiritual, mental, physical, emotional wellbeing with reported increased perception of the quality of life and belief of better health outcomes. The process or channels in which religion improves the health outcomes or sense of belonging of African immigrants is, however, not explored nor explained in the study (Agyekum & Newbold,

2016). Agyekum and Newbold's study findings also note that when religion is actively practiced with practical help such as employment, housing health, and support network, it was found more helpful to the community. Active participation is, however, not defined or qualified to different individuals and how it affects their health outcomes; hence deeper understanding of the role of religious places of worship and mental health outcomes is needed. Ting and Panchanadeswaran's (2016), like Agyekum and Newbold's, noted that the presence of adverse outcomes did not deter the continued use of religion as the primary influence on decision making among African immigrants. Religion thus remained the primary influence in decision making among African immigrants.

In African traditions, seeking help and support from elders would be the first expected appropriate behavior before turning to health professionals (Ekwonye et al., 2021). However, with African immigrants in the United States, the scarcity of immigrant elders in the community leads to reliance on spiritual leaders for support and coping when facing difficult situations (Ekwonye et al., 2021; Nantwi et al., 2017). The phenomenon is not only noted among younger immigrants but also older immigrants (Adekeye et al., 2014). Adekeye et al. (2014), in a photovoice study done on a convenience sample in a church involving young adults aged 13-18 years and elderly adults above 65 years old, examined views of African immigrants on health resources access and found that most participants, both the youth and the elderly, stated that religion and mental health went hand in hand. They reported solutions to their problems and reported coping better in faith-based organizations. The association of religion and perceived wellness in their mental health is thus synergistic in the study (Adekeye et al.,

2014). Similarly, Ojikutu et al. (2018), in a qualitative study using a constructivist grounded theory to explore the psychosocial mental health of 45 African immigrant women living with HIV, found that most women reported ongoing persistent depressive symptoms, yet most were without formal diagnosis or treatment. Of note, the women were all seeking treatment for HIV and taking their medications but reported seeking religious faith leaders and friends to cope with their emotional health rather than formal mental health care services (Ojikutu et al., 2018). The reliance on religion for coping and survival of mental health issues was thus more faith-based than formal healthcare-based despite access to health professionals (Ojikutu et al., 2018; Adekeye et al., 2014).

In qualitative studies such as Ting and Panchanadeswaran (2016) and quantitative studies (Omenka et al., 2020), the common themes of religious coping for physical and mental issues were clear. However, how religion aids in coping was not elaborated. Ting and Panchanadeswaran (2016) reported that African immigrant women domestic abuse survivors use religion to cope with abuse through acceptance rather than seeking formal mental health care services. However, the women also reported feeling marginalized, not getting help, and feeling misunderstood by faith-based leaders suggesting religion may have negative impacts on coping. Religion was consequently the frame and backbone of coping despite the social issues faced among African immigrants.

The Role of Religious Leaders in Informal Caregiving

Wharton et al. (2018) used focus groups to investigate mental health use among African American adults, which did not distinguish African immigrants and United States-born African Americans, as noted in other studies (e.g., Agbemenu, 2016;

Freeland et al., 2020; Nantwi et al., 2017; Omenka et al., 2020) and found that informal health seeking was most often to elders in the community and church clergy superseded formal mental health care. Faith-based help was also more suitable for concrete life events such as a death in the family rather than subjective events such as marital conflict or abuse. The subjectivity of which events get help can lead to isolation among immigrants undergoing the later events from fear of getting stigmatized hence they are more unlikely to get assistance in such situations (Freeland et al., 2020; Ting & Panchanadeswaran, 2016). Jangu et al. (2021) concurred in a qualitative study among Black faith leaders from Christian and Islam religions using semistructured interviews in a grounded theory. Authors found that 75% of faith leaders in the study felt a need to address controversial subjects such as divorce, homosexuality, or issues such as HIV in their congregations but feared detrimental effects such as reduced attendance, reduced tithing, and alienating parishioners thus kept quiet about such subjects (Jangu et al., 2021).

Despite the reliance of African immigrants on religion for direction, social support, and coping, it is, however, not always provided by both leaders and some religious organizations, as noted by the findings of Ting and Panchanadeswaran (2016). Feelings of increased isolation, fear of being blamed, misunderstood, negative feelings, lack of practical help, and stigmatization did not change the help-seeking behaviors among African immigrants with noted continued reliance on elders and religious leaders (Agyekum & Newbold, 2016; Nantwi et al., 2017; Ting & Panchanadeswaran, 2016). Interestingly, a classic grounded theory study of 35 clergy faith leaders from the United

States, Africa, and India explored how religious leaders handle depression, suicidal thoughts, posttraumatic stress disorder, and anxiety. Findings indicated that most clergy members felt ill-equipped to handle mental illness despite the high influx of members seeking mental healing, and they felt the need for higher training (Payne & Hays, 2016). One sermon a year on topics of mental illness was the average among the faith leaders' teachings to their congregations (Payne & Hays, 2016). The 35 clergy members noted the reason for mental illness as varied, but none noted biological reasons or chemical imbalances. They also all noted that faith leaders have a role in treating the mental illness even though it would be collaborating care (Payne & Hays, 2016). Understanding how religion plays a role in mental health care use is thus crucial as it continues to be the first line for African immigrants, and the information gathered would contribute to the knowledge gap of faith-based leaders on how to collaborate with mental health providers in caring for their congregation.

Religion and Wellness

Religion is also attributed to overall wellness (Ekwonye et al., 2021). Ekwonye et al. (2021) used an exploratory approach using phenomenology to explore African immigrants' meanings of life, and the findings note that religion was used as a lens for viewing their lives and wellness. Their levels of wellness were attributed to the extent of their alignment with their spiritual beliefs implying that the greater their religious alignment, the more likely their perceived wellness and wholeness. It is essential to note the findings from Ekwonye et al. (2021) did not attribute wholeness and wellness to wealth, education level, socioeconomic status but to feelings of peace, contentment, and

quality of life despite their current health circumstances; thus, even those suffering from health issues reported their wellness as good due to their religious alignment. Study findings also note that about 75% of the African immigrants attribute their lives as predestined by a higher power (Ekwonye et al., 2020). The attribution of wellness to religion hence was noted as a contradiction to their health status as their connectedness to religion was more of value than their actual health status (Ekwonye et al., 2020). The author thus concluded that despite the role of religion being a lens of their circumstances, the actual role remained misunderstood with its positive or negative implications towards mental health care use as wellness was attributed to the connectedness to religion rather than health status (Ekwonye et al., 2021).

Wellbeing is also studied by Areba et al. (2018) related to Somali immigrants in Minnesota, where more than 2,200 Somalis reside. Somalians in the United States are mainly refugees seeking asylum from political instability in their home country. Thus, they have undergone traumatic experiences and may have long-term emotional difficulties such as anxiety and depression (Areba et al., 2018). In a cross-sectional study of 156 Somalis in Minnesota to examine associations of religious coping, signs of depression/anxiety, and physical/emotional wellness, a high association of positive religious coping such as acceptance of situations or using religion to forgive was associated with a greater sense of wellbeing (Areba et al., 2018). Consequently, negative religious coping such as displeasure with the clergy, questioning God's power was associated with a lesser satisfaction with life, decreased overall wellness (Areba et al., 2018). Areba et al.'s (2018) research thus mirrors Ekwonye et al. (2021) in noting that

religious affiliation was associated with a higher level of perceived wellness among African immigrants irrespective of their current situations.

Mental illness

Mental illness among African immigrants is understudied as it is not considered an actual disease in many African communities (see Agbemenu, 2016; Habecker, 2017; MHA, 2020; Omenka et al., 2020; Shoup et al., 2021; Wharton et al., 2018;). Several authors described mental illness as a "silent crisis" which remained underdiagnosed and undertreated (see Ojikutu et al., 2018; Monnapola-Mazabane et al., 2021). Among African communities, illness has often been described as a result of human inadequacies (Agbemenu, 2016), a result of a curse on a family (Habecker, 2017), spiritual disharmony (Senrich & Olusesi, 2016), from magical spells and voodoo (Ludwig & Reed, 2016), from evil spirits and demonic interference (Omenka et al., 2020) and also from God's will (Agbemenu, 2016; Omenka et al., 2020; Senrich & Olusesi, 2016) thus the opposing perspectives and attitudes towards mental illness among African immigrants enhance the difficulty in the use of mental health care.

A higher risk of mental illness, especially depression, among immigrants due to elements of immigration such as acculturation, premigration trauma, challenges in obtaining citizenship, economic hardships, and expectations from their home countries has been noted in both qualitative and quantitative studies (see Agbemenu, 2016, Blackmore et al., 2020; Panettiere et al., 2017; Ojikutu et al., 2018;). Blackmore et al. (2020), in a comprehensive scoping review of 21,842 journals from 2003 and 2020 using a descriptive approach across 15 countries which included two African countries, found

high and persistent levels of post-traumatic stress disorder, depression, and anxiety among immigrants in their host countries necessitating the need for continued mental health care in their host countries. Panettiere et al. (2021) also noted a high incidence of mental illness among African immigrants in the United States in a cross-sectional survey conducted to measure anxiety and depression symptoms at the time of the study (N=2,468) using the PHQ-4 assessment for depression. The authors noted that reasons for immigration also impacted participants' mental health, with traumatic immigration resulting in higher incidences of mental illness. Immigration status, support in the host country, employment status, and support system correlate to mental health status (Panettiere et al., 2017). Immigrants depending on their immigration status were thus noted to have increased stressors that could lead to mental illnesses.

Mental Health Care use among African Immigrants

MHA (2021) reports that 27 million adults with diagnosed mental illness remain untreated. The Southern States, where a higher black population is highly associated with less use of mental health care services (MHA, 2021). Despite reports of an increase in the black population from immigrants from other countries, MHA (2021) data was not categorized per immigrant group, but an overall reduced use of mental health care was noted among black America. This section will cover the different aspects that affect mental health care use among African immigrants

Mental Health Care Use in Africa. The status of mentally ill persons in countries of origin affected mental health care use in the host country (Ojikutu et al., 2021). Ojikutu et al.'s (2021) findings reported that many of the known and diagnosed

cases of mental illness were institutionalized in Africa, thus creating a phenomenon that mentally ill persons could not live in the community with other people, leading to the fear of a diagnosis of mental illness. Monnapola-Mazabane et al. (2021), in a scoping review of peer-reviewed journals from 2008 to 2019, noted that mental illness in African countries is not as professionally researched as other diseases like AIDS or Malaria, and there is a lower density of mental health workers with a lower rate of mental healthcare usage in African countries. Like the findings of Ojikutu et al. (2021), mentally ill persons were also more likely to be institutionalized or hidden indoors by families for fear of being labeled as crazy or being shunned from their communities (see Monnapola-Mazabane et al., 2021). The fear hence gives mental illness a negative connotation as African immigrants leave their country. Ojikutu et al. (2018), in semi-structured interviews of 45 African immigrants in the United States, finds that more than half of the participants report the institutionalization of mentally ill persons in Africa contributes to the overall view of mental illness as a negative disease that brings shame to a person or family. Given the enculturation that occurs with African immigrants (see Nguyen, 2020; Omenka et al., 2020; Shoup et al., 2020), the shame, stigma, and negative stereotypes are carried forward to their new countries, thus the reduced rates of mental health use in the United States despite the availability of services.

Conflicts with Religious Preferences. Controversies are also noted among faith leaders' teachings and access to care. An in-depth qualitative research study involving 17 African immigrants in the United States to explore the potential impact of culture, health, and religious activities on health-seeking preventative behaviors, Freeland et al. (2020)

note that religious preferences delay access to care. Findings from the study were that religious preferences affected health care use and especially attitudes towards prevention, where 50% of the participants voiced that accessing preventative measures would inadvertently cause them to have the disease by speaking it in their lives (see Freeland et al., 2020). Religious preferences also supersede formal access to care despite the gravity of the symptoms suffered (Freeland et al., 2020). The study is consistent with reports from MHA (2020), which noted that there was delayed seeking of formal care for mental illness among blacks in the United States due to seeking family, clergy, and other sources hence leading to increased severity and chronicity of mental illness, among other diseases.

Both Islam and Christian religions ascribe health and wholeness to God. Olukotun et al. (2019) reported that findings from interviews conducted among African immigrants reported that there were feelings among 75 % of the participants that reliance on western medicine and doctors without seeking religious beliefs would be a conflict with their beliefs and may bring ‘bad luck. Such notions can also delay seeking care among African immigrants despite the awareness of mental illness in the family. Ekwonye et al. (2021) and Ting and Panchanadeswaran (2016) reported the conflicts of religious and traditional beliefs as barriers to health care use as help-seeking actions on formal mental health services might be viewed as contradictory to their belief system. The beliefs of health outcomes being predetermined, whether by curses in the family or by an act of supreme power, also brought about delay in access to care due to the futility associated with healthcare use (Olukotun et al., 2019). Preventative medicine, pharmacological solutions,

et cetera were thus viewed as supplementary to religious practices which are not clearly defined (see Sackey-Ansah, 2021; Omenka et al., 2020).

Perceived Etiology of Mental Health Illnesses. Some diseases and health imperfections, especially mental illness, were also viewed as consequences of human inadequacies because of sin, cursing, prayerlessness, or as a God-ordained timeline for an individual to teach him something in Christian, Islam, and indigenous religions among African immigrants on multiple studies (Ndaita, 2018; Omenka et al., 2020; Sackey-Ansah, 2021; Saasa, 2019). This belief has been found to influence reactions towards diseases management and health-seeking behaviors as first-line defense is tackling the etiology of the disease. Traditional healers, exorcism, animal sacrifices, repentance are reported to be the first line of treatment with medical care as a last resort, thus delayed care in African countries (Sackey-Ansah, 2021). The delay in care was consistent with studies in the United States involving black Americans not differentiated from their origin with access and use of mental health care, where those accessing care have a greater severity and chronicity from delayed care (MHA, 2020; Wharton et al., 2018).

Discrimination and Shame. Discrimination also affects mental health care use among African immigrants. Nkimbeng et al. (2021), in a descriptive study exploring experiences of discrimination and impact on health care use, found that African immigrants experienced microaggression. Perceptions of microaggression were attributed to their African accents, and the perceived discrimination was associated with poor physical and mental health from reduced or delayed health care use (Nkimbeng et al., 2021). The associations of perceived discrimination and poor mental health outcomes

were also consistent with studies done by Brown et al. (2018). Older, black African immigrants reported more discrimination due to lower health care literacy, language deficiencies, and lack of translators (Nkimbeng et al., 2021).

Lower use of mental health services were also noted among second-generation African immigrants, where the children are American-born to African immigrant parents (see Echeverria-Estrada & Batalova, 2019, Escamilla & Saasa, 2020; Obideyi & Sangmin, 2021). Obideyi and Sangmin's (2021) findings in a longitudinal survey of 104 African immigrants found lower use of mental health services among second-generation children or immigrant children due to their parent's reluctance to such care despite access to mental health services in schools. The study was consistent with the results of Echeverria-Estrada and Batalova (2019), which found that the ingrained beliefs from parents transfer to their children; thus, children also viewed mental illness as an anomaly and not a disease that needed treatment, leading to lower mental health care use. In 1st and 2nd generation African immigrants, perceived discrimination was noted to cause a delay in access and use of mental health care, especially among African immigrant men who report feelings of emasculation from discrimination, therefore preference not to seek formal care (Escamilla & Saasa, 2020). The issue penetrates the African immigrants despite education levels where Olokotun et al. (2019) determined in an explorative study using semi-structured interviews that educated parents were more likely to use mental health services for their children but less likely to disclose information to other African immigrants. This was found to be a result of thoughts of shame of having a mentally ill child, disgrace, and further isolation from their communities, a phenomenon noted by

multiple researchers (see Ekwonye et al., 2021; Olokotun et al., 2019; Omenka et al., 2020; Ting & Panchanadeswaran, 2016; Wharton et al., 2018;).

An elevated level of shame on families with mental illness, shunning from communities, and isolation leads to a lack of mental health care use among this population group in young immigrants (Nantwi et al., 2017) and middle-aged immigrants (Echeverria-Estrada, & Batalova, 2019) with worse outcomes in older immigrants who have more barriers including language, illiteracy, and socioeconomic status (Agyekum & Newbold, 2016). Results of a cross-sectional survey of 409 African Immigrants in the United States represented from 31 African countries found that although exacerbating factors of mental illness remains high from the pressures of acculturation, language barriers, discrimination, and cultural acceptance of gender violence, the mistrust of health professionals/western medicine and fear of shame in the communities create barriers to seek care (Escamilla & Saasa, 2020). In a larger-scale study of 1,908 African immigrants, Brown et al. (2018) reports a prevalence of perceived discrimination and psychological distress, yet only 10% of African immigrants seek mental health care. These numbers are consistent with African Americans' mental health care use in the United States (National Institute of Mental health, 2020, Wharton et al., 2018).

Views on Preventative Care. Prevention is also frowned upon due to multiple beliefs about diseases being a bad omen, a curse, a result of spoken word, and a collectivistic culture where it is considered taboo to speak about ailments. Freeland et al. (2020) noted that practicing active prevention of diseases or screening brought about negative feelings and reduced quality of life with a feeling of not wanting to know about

their health among the participants. The belief of death is also considered the expiration of one's life on earth, which is predetermined, hence posits that even with medical intervention, God has ultimate control (Freeland et al., 2020; Sackey-Ansah,2021). As a result, there are perspectives of futility viewed when dealing with diseases which also leads to delayed health-seeking and lack of health service use.

Perceived Overdiagnosis. Overdiagnosis was a common ideology in describing western medicine among African Immigrants (see eFreeland et al., 2020; Ludwig & Reed, 2016; Payne & Hays, 2016). Ludwig and Reed (2016), in assessing views of health care use among African immigrants using a framework thematic analysis, reported findings of immigrants feeling ‘over diagnosed’ in the United States with statements like “when you are here, you have hypertension, diabetes, and cholesterol.” The views of overdiagnosis wase attributed to access to preventative health care but ended up with a negative connotation on the immigrants with fear that accessing health care was equitable with being labeled with diseases (Ludwig & Reed, 2016).

Preferences in Health Care Services. Results of an ethnographic study of 68 African Immigrants residing in New York on their views for health and access to health services by Ludwig and Reed (2016) indicated that those seeking mental health services preferred ethnic clinics that integrate spirituality and religion with western medicine. The study also noted that mental illness was more prevalent among refugees arriving from war-torn countries with no social support system and language barriers as they acculturated to the dominant culture compared to voluntary immigrants, which were similar findings to Ojikutu et al. (2018) and Panattiere et al., 2017. Still, Senreich et al.

(2016), through focus groups, considered the assistance offered to African refugees upon immigration to the United States. They noted reliance on religion, marijuana abuse, and lack of comprehensive culturally inclined mental health services to utilize after their immediate settlement in their new habitation leading to more isolation and thus higher reports of depression anxiety, and mental illnesses. The findings from the study also showed a lack of familiarity with mental health services among African Immigrants due to the lack of those services in their home countries, thus a less likelihood of their use in the United States despite their accessibility (Senreich et al., 2016).

Mental Health Providers and African Immigrants

In an explorative listening study of psychiatrists examining their opinions and experiences dealing with African immigrants' mental illnesses, BeLue et al. (2021) findings noted that all psychiatrists (N=8) felt ill-equipped to deal with the cultural inferences among African immigrants. They voiced not feeling well prepared for culturally responsive care needed for the immigrants (BeLue et al., 2021). National Alliance on Mental Illness [NAMI] (2021) reported that there was a great need for culturally competent mental health providers in the United States, especially when dealing with the black population, who were more likely to describe physical symptoms as related to mental health issues such as body aches when reporting depression. Lack of cultural awareness with a conscious or unconscious bias towards black Americans who include African immigrants, may thus lead to misdiagnosis and inadequate treatment (see NAMI, 2021). BeLue et al., (2021) findings also noted the difficulties experienced by psychiatrists providing care to African immigrants included mistrust of the systems of

care, the stigma of being labeled as crazy where some would accept taking an antidepressant for pain but not for depression. Mistrust of interpreters or translators who spoke African dialects rather than focus on mental illness being a priority to the African immigrants were also listed as challenges for these providers.

Olukotun et al. (2019) reiterated the need for cultural and religious competence among mental health practitioners in dealing with African immigrants rather than grouping African immigrants as "black." Similarly, Omenka et al. (2020) noted that grouping African immigrants as black, though phenotypically like African Americans, produces erroneous assumptions in their care due to different health outcomes such as lower cardiovascular risks, higher birth weights than African Americans. There is little data on African immigrants' mental health, health care use, or long-term care in the United States. The lack of studies focused on individual migrant groups like African immigrants where providers can expand their knowledge base can thus relate to the lack of cultural competence among the health providers.

Acculturation

Acculturation can be described as the cultural and emotional vicissitudes when a minority culture interacts with a dominant culture (Agbemenu, 2016). Dominant cultures are the cultures that are a majority in a specific region. As such, in the United States the African immigrant's culture would be the minority culture, whereas the American culture would be the dominant culture (Agbemenu, 2016; Freeland et al., 2020; Shoup et al., 2020). Acculturation affects health choices, health-seeking behaviors, and health outcomes (see Agbemenu, 2016; Ekwonye et al., 2021; Habecker, 2017; Freeland et al.,

2020, Nantwi et al., 2017; Omenka et al., 2020; Saasa, 2019; Shoup et al., 2020). The effects noted are dependent on various factors such as nativity (Shoup et al., 2020), proficiency in the English language (Nantwi et al., 2017), length of stay in the new region (Agbemenu, 2016), age at immigration, educational level, socioeconomic status (Freeland et al., 2020), and cultural attitudes (Habecker. 2017)

The main categories of African immigrants to the United States are either francophone immigrants who are likely from French-speaking countries, coming to the United States through refugee status, more likely to be Islamic, having less English proficiency as compared to Anglophones who are more likely to be English speaking, more likely to be Christians and more likely voluntary immigrants (Shoup et al., 2020). Longitudinal studies (see Shoup et al., 2020) and exploratory observational studies (see Habecker, 2017) determined that Anglophone were more enculturated, with a more extensive support system through family unification programs and religious activities. Thus, had better health access and consequently better health outcomes. Francophones, on the other hand, were noted to have less support due to lack of access to social and religious support from fewer mosques in places of settlement, less access to care due to language barriers and health illiteracy, and had fewer reunification programs resulting in more isolation (see Habecker, 2017; Shoup et al., 2020).

Despite trying to acculturate, some immigrants faced identity confusion where they did not view themselves as full Africans or African Americans. Multiple authors noted that the lack of studies on African immigrants regarding their identity, health risks, health care preferences also contributed to identity confusion (see Ekwonye et al., 2021;

Omenka et al., 2020; Shoup et al., 2020; Saasa, 2019). In Ekwonye et al.'s (2021) study of African immigrants, all participants reported confusion in completing medical forms where the black category is not clearly defined, leading to African American, African immigrants, Hispanic blacks, Indian blacks either reporting to be 'black' or 'other' category. The lack of specificity thus created a form of identity confusion, where African immigrants almost always chose the black category despite feeling it did not adequately describe them.

The age at the time of immigration is also an essential factor in health care use and should be considered in treatment. In a longitudinal study of 482 African immigrants aged 20 to 65, enculturation was found to be protective against cardiovascular risks due to the increased social and collectivistic culture of African culture, which limited the likelihood of adoption of adverse risk factors such as smoking and drinking among immigrants coming to the country before they were 20 years old (Shoup et al., 2020).

Habecker (2017), through an observational study of African immigrants (N=37), showed that immigrants did not leave their religious and cultural beliefs and experiences behind after immigrating and were likely to carry the beliefs in their new region. Interviews on adolescents, families, and parents from a mix of 17 African countries in a Lutheran church noted that despite the number of years they had spent in the United States, 75% still identified themselves as Africans, including 50% of adolescents who came to the country as young children. The adolescents considered themselves Africans but considered themselves "too white" for African Americans and "too black" for Caucasians. The adults who represented 70% of the participants expressed feeling most

comfortable eating African foods, wearing African clothes, and speaking in their dialects but felt they had to switch to “American ways” to be more easily understood at work or social places (see Habecker, 2017). Shoup et al. (2020) also noted similar trends of Habecker's (2017) enculturation among older and younger African first-generation immigrants who were the first African-born family members to gain permanent residency in the United States.

Theoretical Foundation

The Theory of Reasoned Action was developed in 1970 by Ajzen and Fishbein (Ajzen, 1985). The construct of behavioral control was later added, and the theory was refined to form TPB in 1980 (Ajzen, 1985; Boslaugh, 2019). TPB is a cognitive theory used to predict and understand an individual's intention to perform a particular behavior through understanding the relationship between human behavior and motivation (Boslaugh, 2019; LaMorte, 2019). The theory has been successfully used to predict health behaviors such as health care use, smoking cessation, drinking, drug abuse, medication compliance, et cetera (Boslaugh, 2019).

Constructs of TPB

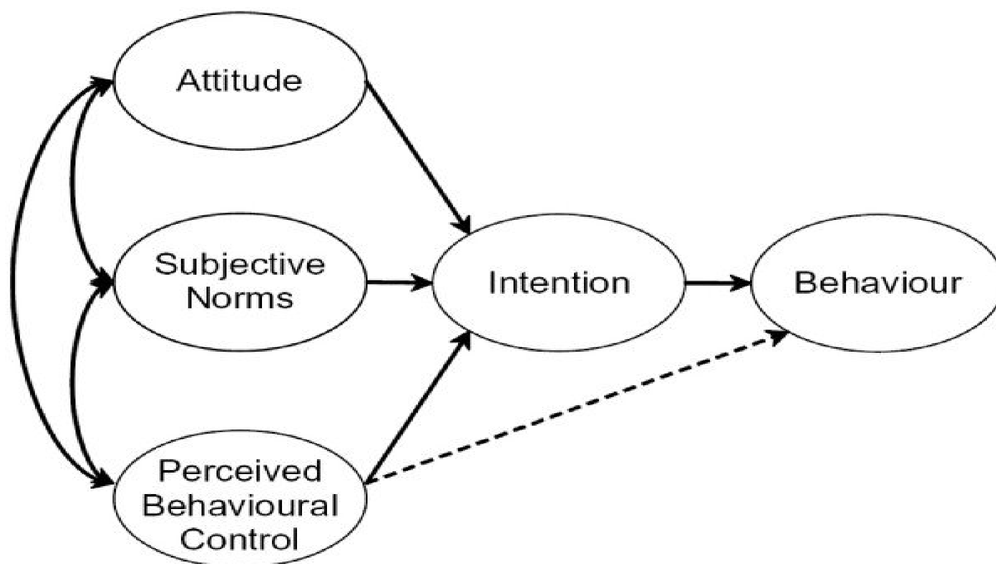
There are several constructs of the TPB (Boslaugh, 2019; Lamorte, 2019).

1) Behavioral beliefs are the individual insights and opinions that certain behaviors would produce specific outcomes. These beliefs influence the attitudes towards performing behaviors based on whether the outcomes are positive or negative; hence if outcomes are perceived as negative, the attitude towards the behavior is negative (Boslaugh, 2019; Vaismoradi et al., 2016).

2) Normative beliefs are the behavioral expectations from a group, such as friends, family, or cultural groups (Asare, 2015; Boslaugh, 2019). The normative beliefs influence the individual beliefs due to pressures to conform with the group beliefs. There is less pressure when an individual behaves in a way that conforms with group behavior than when they act oppositely.
3) Control beliefs are the factors that hinder or accelerate an individual in performing a behavior. When an individual perceives difficulty in performing a behavior, they are less likely to perform than when they have ease in performing it (Boslaugh, 2019; LaMorte, 2019)
4) Actual behavioral control is the true extent of performing the behavior using resources and skills needed to complete the behavior

Figure 1

Theory of Planned Behavior



From "Factors influencing the use of public dental services: An application of the Theory of Planned Behaviour" by L. Luzzi, & A. Spencer, 2008, BMC Health Services Research, 8(1), P. 93.

Assumptions

TPB assumes a straightforward or linear executive process from the intent to the actual behavior; thus, it does not account for changes that occur with time, such as acculturation of immigrants in the United States (LaMorte, 2019). The theory also assumes that all individuals would have the same resources, opportunities, or health services access to perform certain behaviors (LaMorte, 2019). As noted, immigrants have varied opportunities depending on many factors, including the reason for immigration, education level, and family presence in the United States (Shoupe et al., 2020). Other variables such as fear, past experiences are not accounted for in behavioral intention and the period between the intent and action is also not addressed; thus, it would be unclear how long the theory would be useful in predicting certain behaviors (Boslaugh, 2019). The period between intent and action is essential since mental illness may limit the cognitive drive to access help from feelings of helplessness and hopelessness; thus, their behavior prediction is not as linear as TPB would expect it to be (MHA, 2020; Shoupe et al., 2020).

Application of Theory to Constructs of Study and Relation to Study

TPB posits that attitude towards behavior, perceived behavioral control, and subjective norms, derived from the primary constructs of behavioral, normative, and control beliefs, are the main themes that influence behavior patterns (Asare, 2015;

Boslaugh, 2019; LaMorte, 2019; Tornikoski & Maalaoui, 2019; Vaismoradi et al., 2016). Using the themes of TPB allows thematic analysis for both latent and manifest content, with coding being completed through probable subthemes for this qualitative study on understanding the influence of religion on mental health use on African immigrants in the United States.

Behavioral intentions are motivational factors influencing behavior; thus, the more robust the intention, the more likely the behavior's engagement (Asare, 2015). Understanding the role of religion in mental health care use is essential in fully understanding the motivational factors that would lead to more African immigrants seeking mental health care help. Capitalizing on these motivational factors can thus predict positive behavior among African immigrants, according to TPB (Boslaugh, 2019). Behavioral intentions among African immigrants are essential in understanding their experiences with mental health care use. If their motivational factors remain low such as lack of culturally competent health care providers (Ekwonye et al., 2021), lack of mental health knowledgeable clergy (Payne & Hays, 2016), or language barriers (Omenka et al., 2020), then their intentions remain low and consequently increase lack of mental health use both formally in clinics as well as in their religious institutions.

The attitudes towards behavior are the favorable or unfavorable appraisal from the behavior and comprise behavioral beliefs and outcome evaluations. Positive attitudes from a religious perspective are consequently fundamental to understand as multiple authors findings concur that the African immigrants first-line source of help is less likely to be formal mental health care and more likely to be religion (Adu-Boahene et al., 2017;

Echeverria-Estrada & Batalova, 2019; Ekwonye et al., 2021). The positive attitudes can then be used to foster more engagement in the desired help-seeking behavior. If the appraisal is unfavorable, engagement would be unlikely in the behavior (Monnapola-Mazabane et al., 2021).

The subjective norm is the social pressure to perform or not to perform a specific behavior. The subjective norms in religion among African immigrants to be discovered through the research would provide a greater understanding of the role of religion in mental health care use. These norms can be used to used positively to enhance community participation to increase behavioral intention, thus increasing mental health care use. This construct is vital in immigrant societies due to the value of community support (Agbemenu, 2016; Asare, 2015; Ojikutu et al., 2018; Omenka et al., 2020; Wharton et al., 2018). Behavioral control or the ease or difficulty of performing behavior can also be understood in the study; hence future interventions of reducing if not eradicating the barriers can be implemented by the religious organizations and health care providers to increase health-seeking behaviors (Asare, 2015; Vaismoradi et al., 2016). TPB will thus assist the researcher in understanding how religion among African immigrants interacts to facilitate or hinder mental health care use.

Literature Analysis on Use of Theory

Berkley-Patton et al. (2019), in a longitudinal study, used TPB and community-based participatory research to collaborate with the black church to foster HIV testing interventions and found that there was an increase in HIV testing in church-based testing relative to controls. The stigma associated with AIDS/HIV among the black community

has been linked to reduced healthcare use rates; thus, Berkley-Patton et al. (2019) tested the feasibility of HIV testing outcomes of Taking It to the Pews (TIPS), a multilevel HIV education and testing intervention. The constructs of HPB were tested at monthly intervals and included the intention of HIV testing in the church, attitude about church testing, perceived norms about HIV communication in the church through sermons or bulletins, and perceived behavioral control of whether participants could test for HIV in the church. Testing noted increased HIV testing in the church at six months, which correlated with increased intention to test, positive attitude of testing benefits, increased norms of discussing HIV in the church, and the perceived behavioral control of the intent to go ahead to test.

Lefevor et al. (2020), in a multilevel modeling study of 298 participants from 20 congregations across Islam, Christianity and Judaism, examined individual and congregational factors that played a role in psychotherapy-seeking behaviors. The primary constructs studied in TPB were attitudes to seeking treatment and subjective norms beliefs around seeking psychotherapy. They found that increased scripture reading, and service attendance were negatively correlated with help-seeking behaviors. Religiousness thus influenced therapy seeking through influencing attitudes towards seeking treatment, norms, and perceived behavioral control of psychotherapy. The panegyrization of mental health by religious leaders may encourage help-seeking through changing attitudes and norms hence increasing the perceived behavioral control towards mental health care services.

Taylor et al. (2019) mirrored Lefevor et al. (2020) in finding that the TPB in research successfully demonstrated the various factors contributing to the underutilization of psychological help among African Americans. TPB was utilized in their study to examine perceived negative outcomes associated with seeking care, such as stigma and shunning from communities, which reduces the likelihood of the behavioral intention. The social pressures such as endorsement of beliefs that black people do not get depressed, do not seek help, must be strong, or that seeking mental services means one has a weak prayer life increases the subjective norms, which in turn reduces the intention of health-seeking behaviors (Taylor et al., 2019). The perceived difficulties of seeking help such as microaggression, mistrust by health professionals, lack of culturally competent providers, difficulties discussing race and ethnicity in therapy also contribute to perceived behavioral control. When perceived difficulty is high, the attitudes are negative, and the behavioral intention is low, thus increasing the underutilization of mental health services (Taylor et al., 2019).

TPB research is not limited to mental health care use but also to preventative screening services. Edelstein et al. (2020) studied the use of TPB in an ethnographic study to screen for bone mineral density across multiple ethnic groups of one hundred people each among Israeli-born Jews, Israeli-born Bedouin Muslims, and Jewish immigrants from the former Soviet Union through face-to-face interviews. The former Soviet Union immigrants had the lowest screening behavior and more robust religious views, like Lefevor et al. (2020). Consequently, they noted lower scores on the TPB constructs such as lower knowledge, negative attitudes to assessing, discouraging

subjective norms, and lower intentions to screening behavior. TPB can be used to examine the numerous factors that contribute to lower healthcare use.

Summary

In this study, I seek to gain a deeper understanding of the role of religion in mental health care uses among African immigrants. The significant themes noted in the literature review from recent data are religion, mental health perceptions, acculturation, mental health use, and stigma. Data from peer-reviewed journals indicate that religion plays a role among African immigrants' mental health care use, but the way religion impacts the use is not understood. Religion has been identified as an essential factor in most studies examining the underusage of health care services; thus, studying the role of religion in mental health-seeking behaviors is paramount in this migrant group. The current study will examine the role of religion on mental health care use among African immigrants using the constructs of the TPB such as attitudes, behavioral control, and subjective norms. The use of qualitative ethnographic processes using semi-structured interviews will hence provide more profound knowledge and understanding in filling this identified gap.

Chapter 3: Research Method

The purpose of this study was to provide a qualitative exploration and understanding of the impact of religion on mental health care use among African immigrants in the United States. The information gained from this study built on available literature on African immigrants in the United States to inform clinical care on management of African immigrants' mental health with the aim at an overall improvement in the quality of care received by African immigrants regarding their mental health, thus improving their quality of life. This chapter will describe the research design, rationale, the population, data collection procedures, the role of the researcher, explain the methodology with instrumentation, data analysis plan as well as discuss issues of trustworthiness and ethical considerations

Research Design and Rationale

The purpose of this study was to understand the role and impact of religion in mental health care use among African immigrants in the United States. The following research questions guided the study:

RQ1: What are the experiences of African immigrants in the United States with mental health care use?

RQ2: How does religion influence mental health care use among African immigrants in the United States?

The study was a qualitative in approach with an ethnographical research design. Qualitative studies provide a deeper understanding of the subject, thus yielding in-depth data about the community (Burkholder et al., 2016). Through ethnography, cultural

groups such as African immigrants in the United States are studied to understand their characteristics and way of life. As such, the role of religion to African immigrants was examined as it related to mental health care use in the United States. Ethnographic studies examine people in their environment through various methods (Morgan-Trimmer & Wood, 2016). I used semistructured interviews to get data and study the African immigrant population in Houston, Texas.

Semistructured interviews provide a guide to ask questions but also provide leeway for interviewers to probe for more data as well as allow the interviewee to provide as much information as they need in detail, thus adding to the depth of the qualitative research (Burkholder et al., 2016). The interviews occurred in the United States in the natural settings/environments where participants live, work, or play, which is an essential element in ethnographic qualitative studies (see Aspers & Corte, 2019). This element helped me understand the lived experience of African immigrants in the United States regarding their religion and mental health care use.

Ethnographic studies help understand cultural groups or subsets of populations which helps decipher them and understand their way of life and their behaviors (Morgan-Trimmer & Wood, 2016). My ethnographic study was instrumental in understanding the fastest-growing immigrant group in the United States, African immigrants, thus provided useful information regarding how religion impacts their mental health care use, which inevitably improves their health outcomes by enabling health providers and religious leaders to work together to improve mental health among African immigrants in the United States.

Role of the Researcher

As the researcher, I conducted all interviews using semistructured interviews, which allowed me to obtain more information through a two-way communication where not only the answers to the questions are answered, but also the reasons behind the answers are prodded. Interviews were set up in natural, informal settings where they lived, worked, or played to ensure the participants were comfortable and could provide in-depth information. As the researcher and an African immigrant living in the United States, I needed to exercise a lot of self-reflection using a reflexivity journal to ensure that my thoughts and opinions were not reflected in the interviews or analysis of the study. Regarding my role of being an African immigrant yet being the interviewer, Pessoa et al. (2019) suggested that ignoring the social differences and social roles can produce an oppressive research process where the interviewee feels their life experiences are the only part of importance. As such, reflexivity was used where I could share my thoughts on my role, thus exposing personal biases that may be present and integrating reciprocity into the development of the knowledge acquired.

I did not have any professional or supervisory relationships with the participants in the study that would involve power over the participants. To ensure this professional relationship, I informed each interviewer of my role as a researcher and the need to remain objective throughout the study. This was necessary to avoid any biases and to ensure an open, honest interviewing process without any persuasion. The interview guide used the why, what, where, how, and when questions to understand the meaning and interpretation of their experiences.

Methodology

I used an ethnographic qualitative design to understand the role of religion on mental health care use among African immigrants in the United States. An ethnographic design allowed me to study the cultural group, which in this case was African immigrants, in their natural settings to understand their behaviors and characteristics that make them behave in a certain way, where in this case was the role of religion in mental health care use (see Ravitch & Carl, 2016). Ethnographic researchers collect firsthand, high-quality data, thus producing in-depth information about the cultural group being studied (Morgan-Trimmer & Wood, 2016). I used semistructured interviews, which allowed for more information rather than a rigid question and answer modality of structured interviews. The interviews took place in a conversational mode which was easier for the interviewee to divulge information and feel more comfortable with the interview process.

Population

The population of interest was African immigrants residing in the United States for at least 3 years since immigrating. Participants chosen had to have immigrated to the United States as adults. The sample chosen was English-speaking and living in Houston, Texas. I attempted to recruit from varied and multiple African countries to offer a diversified ethnic background for the research. The participants were above 18 years old with no preference in gender or occupation.

Sampling Strategy

Purposeful sampling strategies were employed in the research study. Purposeful sampling is essential in qualitative studies to ensure that the participants provide the specific data needed. Participants were carefully recruited to ensure they were African immigrants who were legal immigrants in the United States, immigrated as adults and had at least 3 years of residence in the United States, spoke English, and were above 18 years of age. Purposive sampling ensured participants met the screening criteria hence it was an appropriate strategy for an ethnographic qualitative study where a specific culture was investigated (Ravitch & Carl, 2016). Qualitative studies do not have a set sample size, and data saturation determines the sample sizes. Data saturation was described by Creswell (2015) and Vasileiou et al. (2018) as the point in research where no new information is discovered and the point where there is data redundancy. Data collection continued until saturation was reached. Studies on data saturation have identified that in inductive thematic analysis studies, approximately 80-90% of all concepts identified were noted in the first 10-12 interviews (Guest et al., 2020; Francis et al., 2010; Namey et al., 2016). I hence estimated about 10 participants to reach saturation.

Instrumentation

Semistructured interviews were used to investigate and gain a better understanding of the phenomena of interest, which was the role of religion in mental health care use. The interviews were also framed around the TPB and ethnographic qualitative design. I focused on behaviors among African immigrants residing in the United States Ravitch and Carl (2016) emphasized the need for interview questions to

align with the research question to ensure that the research questions are answered, and methodology is followed. The interviews questions were framed around understanding mental health perception among African immigrants and understanding the role of religion in their everyday lives. All questions were descriptive, open-ended, neutral, and non-leading to elicit a more in-depth information base (see Patton, 2015). I developed all the interview questions using TPB to provoke the theoretical concepts discussed in Boslaugh (2019). The interview guide is attached in Appendix B.

Journal notes during the interview, as well as observation during the interviews, provided a varied data collection method and triangulation. Journal notes were essential for analysis using a summative approach as they provided more interpretive data (see Ravitch & Carl, 2016). Observation of nonverbal cues such as hesitation, laughter, and facial expressions enabled me to probe for the thoughts behind the reactions, thus enriching the data at hand.

Procedures for Recruitment, Participation, and Data Collection

I posted fliers (see Appendix A) in local African places of worship such as churches and mosques, African restaurants, and local African shops where African immigrants purchase African foods. These areas also served as meeting places for many Africans thus were appropriate to reach the desired population for the study. The fliers contained my contact information, the reason for the study, and the topic of the study. I identified local Christian leaders and Muslim leaders to determine if they were willing to have fliers posted in their places of worship to recruit participants. I also used a

snowballing method by asking recruited participants to pass along my contact information to other people they knew who would be interested in the study.

All inclusion criteria were shared during the recruitment phase, where those who met the criteria contacted me for the study. I ensured those chosen met the inclusion criteria by asking again the criteria questions in the flier once they contacted me with their interest to participate in the study. I chose the first 10 participants who meet the inclusion criteria and scheduled the interviews. I emailed the consent form to each participant and requested their consent to undertake the interview. The informed consent forms provided a brief description of the study, discussed its purpose, procedures, risks, and benefits. Confidentiality and privacy issues were communicated to ensure the participants knew that all information would be protected throughout the study. I made participants aware of free community resources available to them if concerns or potentially triggering points came up in the interview. The time commitment of about 60 minutes was also communicated for participant preparation before the study.

Data collection began after Walden University Institutional Review Board (IRB) approval (approval number 05-20-22-0986249). Individual face-to-face interviews were arranged. Due to COVID 19 pandemic, virtual meetings were an alternative optional method. This option was communicated ahead of time while scheduling the interviews. Virtual visit included Zoom which allowed for observation of facial expressions to be noted by the interviewer. I provided an option for face masks for the in-person interviews and disclosed my COVID vaccination status. All interviews irrespective of in-person or virtual were be audiotaped, and field journal notes were taken during the interviews.

Interviews lasted approximately 60 minutes each. The interviews took place in a centrally located library conference room that I booked ahead of time to provide a safe and neutral space for data collection. An alternative location was arranged in the case that the library conference room was not available. The interviews were then conducted by beginning with a brief demographic survey (Appendix C) then followed by semi-structured interviews. I provided closing statements to each participant and debriefed them after collecting data. Debriefing was necessary for the participants to express their thoughts regarding the interview and to offer a relaxed environment before they left the conference room or the Zoom space. The audio recordings and journal notes were stored in a password-protected personal computer for safekeeping. Each participant was compensated after the interview with a twenty-dollar local restaurant gift card. Data collected were then transcribed through Zoom transcription services. Upon transcription, I offered participants a chance to review the typed transcripts for accuracy of the interview. I then coded and analyzed data to identify emerging themes

Data Analysis Plan

The purpose of the study is to understand the role of religion in mental health use among African immigrants in the United States. After data collection, the recorded audio from the interviews was transcribed into a word document. The fields notes and observations were also analyzed manually as they provided richer data collected during the interviews that may not have been recorded such as grunts, smiles, sadness, smirks et cetera. I first typed up the preliminary field notes then manually coded them using a deductive approach. After transcribing the recordings, codes were derived and aligned to

the research questions. I utilized thematic analysis to search for differences and similarities within the data collected, thus summarizing the data into information that could answer the research question. Thematic analysis was developed by Braun and Clarke as a reliable way of qualitative data analysis that involves interview transcripts; thus, it was an appropriate analysis method for this study (Braun & Clarke, 2014). Thematic analysis involves a systematic process:

1. Familiarization with the raw data through transcribing and reading journal notes
2. Coding of the data
3. Generating themes
4. Reviewing themes
5. Defining and naming themes
6. Write up

A deductive approach based on the TPB with a semantic approach was utilized. The semantic approach required analyzing the content rather than the assumptions of the underlying data. I employed manual coding to control and maintain ownership of my work. Parameswaran et al. (2020) states that coding breaks down qualitative data into meaningful phrases that help make sense of the vast data. I chose to use Dedoose software as a qualitative analysis software due to ease of use, cost, transferability, transcription, analysis potency, visualization, data mapping, and privacy maintained by the software. The software thus enhanced coding and theme categorization. The codes were then grouped into categories that formed emerging themes guided by TPB. All

themes were categorized and stored in a password-protected memory card for safe record-keeping.

Issues of Trustworthiness

Trustworthiness is critical in qualitative research as it indicates the authenticity of the study through examining factors such as dependability, credibility, conformability, and transferability (Burkholder et al., 2016; Elo et al., 2014).

Credibility

Leung (2015) describes credibility as the extent to which a study can be believable hence meaning that the data provided can confirm the study. It is hence the measure of honesty and accuracy of the data to establish that it is true. It checks the study's internal validity by how well the research represents the phenomenon studied. To ensure the study's credibility, I utilized member checking, peer debriefing, and triangulation.

Member checking involved returning the results and transcripts of the data collected to the participants to ensure information was accurate and resonated with the information they provided. Member checking ensured high-quality data (Ravitch & Carl, 2016). Triangulation uses multiple approaches to answer the research question (Ravitch & Carl, 2016). It was achieved through varied ways of data collection where information was audiotaped, journal notes were taken, and observation was conducted during the interviews. Peer debriefing was utilized to establish credibility. Peer debriefing involved using an unbiased and independent peer to enhance the validity of the research. This was

achieved through my dissertation committee reviewing all the work presented throughout the research process.

Transferability

Burkholder et al. (2016) describe transferability as a measure of external validity in research that examines the extent to which the results of a qualitative study can be generalized to other settings. Given the scant data of African immigrants and their mental health, I ensured that a detailed, in-depth description was provided regarding the background, project details, methods, findings, assumptions, processes, and outcomes. Elo et al. (2015) posit that the more information provided, the better the study transferability. Participants' descriptions, sample selection, analysis is also needed to offer a more detailed description of the study that enhances transferability.

Dependability

Dependability is the process of ensuring that data remains stable over time, thus ensuring the consistency of data collected, analysis, and reporting in the entire study (Burkholder et al., 2016). Burkholder et el. (2016) reports that dependability is essential in providing reliability and consistency in the research. To ensure such stability, I used triangulation in data collection. Triangulation was ensured through multiple data collection methods, from audio recordings to journal notes and observations, ensuring that the information collected was stable and consistent.

Confirmability

Confirmability ensures that other researchers can verify the study and that the level of confidence in the study is based on participants' narratives rather than

researchers' opinions (Ravitch & Carl, 2016). To maintain conformability in this study, a reflexivity journal was used and maintained throughout the entire study in which I reflected on what happened and record all values and interests of the study. Leung (2015) posits that reflexive journals also ensure that a researcher can acknowledge the process, biases, or any opinion that may affect their objectivity in the project, thus ensuring the validity of the data.

Summary

I used a qualitative design to understand the role of religion in mental health care use among African immigrants living in the United States. The purpose of this study was to provide an explorative understanding of mental health use among African immigrants concerning their religious practices. Information from this study provided more data regarding African immigrant health, thus improving the quality of mental health care received, overall wellness, and reduced disparities among minority groups which produces a positive social change to African immigrants in the United States.

An ethnographic study was conducted using TPB as the guiding framework using semi-structured interviews to ensure in-depth enriched information collection from 10 carefully selected participants through purposeful participant selection. Informed consent was provided to ensure that participation was purely voluntary and to outline the expectations of the study. Data was audio recorded, and journal notes were taken during the interview while maintaining the privacy and confidentiality of the participants. All participants were debriefed after the interview. The data collected was analyzed through thematic analysis to derive codes and themes. Dedoose software was used to assist with

data analysis. To maintain credibility through the study, a reflexivity journal was kept and maintained, triangulation in data collection was verified, and transcripts/results were checked with participants to ensure the accuracy of the data provided. The next chapter will discuss the findings and study results.

Chapter 4: Results

The purpose of the qualitative study was to understand the experiences of African immigrants in the United States with the mental health system and understand how religion influences mental health care use among African immigrants. I used open-ended, semistructured questions to interview 10 participants for the study. The open-ended questions provided in-depth answers to the questions which were all used to answer the two main research questions. The interviews were all in person and each lasted about 60 minutes. The following research questions were used in this study:

RQ1: What are the experiences of African immigrants in the United States with mental health care use?

RQ2: How does religion influence mental health care use among African immigrants in the United States?

This chapter will describe the setting, demographics, data collection procedures, thematic data analysis, evidence of trustworthiness, reporting of the data analysis, a summary of the emerging themes that arose from the data and provide a summary of the whole chapter.

Setting

Approximately 100 fliers were distributed in African religious institutions, restaurants, and shops in the Houston metropolitan area. Participants were recruited through purposive sampling. Individuals interested in participation contacted me through the information provided in the flier. Upon participant contact, eligibility was determined through inclusion criteria, 10 participants met inclusion criteria and were recruited for the

study, and interviews were scheduled. Participants were offered the choice to schedule face-to-face or virtual interviews using the videoconferencing tool Zoom (2022). Five participants choose the virtual option while the other five choose in-person interviews. Semistructured interviews occurred on various dates over 2 weeks from May 21st to June 2nd, 2022. All in-person interviews were held in the conference room of a local library. The conference room was private and only the participant and I were present. There were no interruptions during the interviews. Each in-person interview was audio recorded using a Zoom audio recorder. The virtual interviews were conducted from my home using Zoom. I used Zoom for audio and transcript recording data for both in-person and virtual interviews.

Data Collection

Data collection began after IRB approval was received and took approximately two weeks. Five participants chose virtual interviews over in-person of fears of Covid-19 as well as convenience. All participants were from the Houston metropolitan area and interviews were conducted in English as outlined in the recruitment flier and consent form. Participants provided consent via email before the interviews. Data were collected from a total of ten participants. The obtained data was qualitative using the interview guide (Appendix B) with deeper probing and follow-up questions employed when necessary. For the in-person interviews, I used the Zoom phone application to audio record which also provided the verbatim transcripts while for the virtual interviews, Zoom was also used for both audio and transcription services. Most interviews lasted approximately 60 minutes however, three interviews lasted approximately 80 minutes as

participants wanted to “talk some more”. Saturation was noted on the eighth interview, but I continued with two more interviews to ensure no new information was emerging. Journal notes were taken during the interviews where emerging codes and observations were noted. At the conclusion of each interview, I listened to the audio recordings and reviewed the transcripts from Zoom which had a lot of inconsistencies due to the various accents and pronunciations, and made corrections as needed. There was however no language barriers or misinterpretation of any questions during the interviews. I then emailed each participant’s transcript to them to review for accuracy. None of the transcripts were changed or edited by the participants. I went through each audio recording, transcript, and journal notes again to gain a deeper understanding of the content. All data were stored on a password-protected computer to which only I have access. Data collection went according to plan without any variations or deviations from the methods described in Chapter 3.

Demographics

Participation was limited to African immigrants living in the United States who had immigrated to the United States as adults and had lived in the United States for at least 3 years. Table 1 presents the demographic classifications of the participants which include geographic African place of origin, age range, income range, education level, religious affiliation, and the number of years residing in the United States. Most respondents came from East Africa (*N*=5), South Africa (*N*=3), and with fewer participants from West Africa (*N*=2). I did not have any recruited participants from northern Africa. Most of the participants earned above $80,000 annually, had an

undergraduate degree, and were in the 41-50 age range. There was equal distribution between males and females.

In terms of religion, a majority (*N*=6) were protestant, and the remainder were non-denominational (*N*=3), and Catholic (*N*=1). Figure 2 shows the distribution respondents by African region. Fifty percent of the respondents were males while the other 50.0% were females. Further, most of them had above an undergraduate level of education (*N*=8).

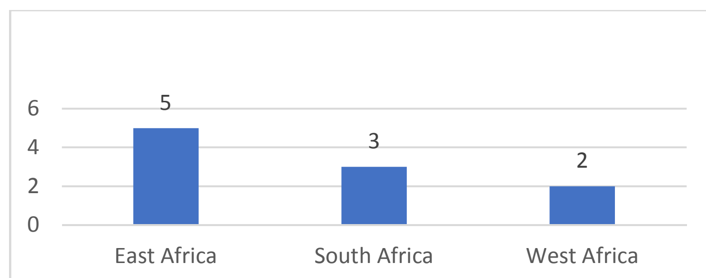
Table 1

Demographic Data

Participant	Gender	Age	Country	Years in United States	Religious affiliation	Education	Income
P1	Female	40-49	West Africa	21-30	Protestant	Graduate	$80, 000<
P2	Female	40-49	West Africa	21-30	Catholic	Graduate	$80, 000<
P3	Female	40-49	East Africa	21-30	Protestant	Graduate	$80, 000<
P4	Male	50-59	South Africa	21-30	Protestant	College	$40,000 - $80,000
P5	Male	40-49	East Africa	21-30	Protestant	Undergraduate	$80, 000<
P6	Male	40-49	East Africa	21-30	Nondenominational	Undergraduate	$80, 000<
P7	Female	30-39	East Africa	11-20	Nondenominational	Postgraduate	$80. 000<
P8	Female	40-49	South Africa	3-10	Protestant	College	$40, 000 - $80, 000
P9	Male	40-49	South Africa	11-20	Protestant	Undergraduate	$40, 000- $80, 000
P10	Male	40-49	East Africa	21-30	Nondenominational	Graduate	$80, 000<

Figure 2

Distribution of Respondents by Region



Data Analysis

The purpose of the study was to understand the role of religion in mental health use among African immigrants in the United States. After data collection and proofing of all transcripts, I saved the note form of the transcripts from Zoom into a Microsoft Word document. I then printed out all the interview transcripts and color-coded the responses according to each question in the interview guide. Responses to each question were thoroughly evaluated to look for similarities and meaningful phrases. I used the actual phrases rather than implied meaning to ensure that I remained as objective as possible to what the participants were stating rather than what I thought it meant. I looked for meaningful phrases for each individual participant and then looked for similarities in those across participants. Descriptive coding was used by summarizing content into a descriptive word. This process resulted in 40 descriptive codes. According to Parameswaran et al. (2020), coding is used to break down data into meaningful phrases. Coding thus involved two stages to bring meaning to the raw data. The first initial round was used as a summary to describe the quotes from the raw data then the second

deductive coding added an interpretative thematic analysis while answering the research questions.

I then grouped the codes into categories that represented an underlying common idea. The broader categories were then combined to form themes which were named based on the key topics and were organized by research question. Ravitch and Carl (2016) define themes as perceptions derived from research. I used thematic analysis to make meaning of the derived perceptions to identify the interactions, associations, and differences within the collected data, and to summarize the data into information that can answer the research questions. The final themes were hence identified and determined from classification of the categories based on responses and research questions.

I then used Dedoose (2022), a qualitative analysis software for further thematic analyses and coding which also ensured further validity. Dedoose was useful in making sure a thorough analysis was conducted. With Dedoose, I imported the cleaned-up word documents into the software, one document for each participant. I then set up descriptor data, a tag in the Dedoose software, with demographic data for each corresponding word document and linked each descriptor data to the corresponding word data document already uploaded. Demographic information included in the descriptor data were presented in Table 1. Dedoose requires a thorough evaluation of the data to develop codes. For this step I used the codes I identified during the manual coding process. Analysis in Dedoose showed the frequency and weight of the codes which confirmed the manual coding results. Since Dedoose relied on identified codes which I had already identified in manual coding, there were no variances between the two methods and the

software allowed me to confirm the weight or frequency of the codes already identified. Table 2 shows the organization of themes, categories and codes derived from the analysis process.

Table 2

Organization of Themes, Categories, and Codes

Theme 1-Insight in mental illness	Theme 2-Treatment of mental illness	Theme 3-Role of religion
Category 1- Definitions of mental illness	Category 5-Cultural influence	Category 10-Education
Category 2-Causes of mental illness	Category 6-Religious influence	Category 11-Normalization
Category 3-Cultural inferences	Category 7-Disclosing mental illness	Category 12-Collaboration
Category 4-Religious inferences	Category 8-Formal mental health perceptions Category 9-Stigma and shame	
Codes *-Curses* *-Consequences of wrongdoing* *-Demons* *-Something is wrong with mind* *-Phobia to mental diagnosis* *-Sadness* *-Lunatic* *-Demon possession* *-Ancestral powers* *-Inadequacies of religious living* *-familial origin* *-shunning*	*Codes* *-Traditional rituals* *-pray and fast* *-do good* *-Sacrifice to ancestors* *-Ignore* *-stigma* *-not sharing* *-hide disease/privacy* *-Institutionalization* *-sharing with non-Africans* *-secrecy* *-shunning* *-racism* *-discrimination* *-stereotyping* *-mind-altering medications* *-side effects* *-addiction* *-not the same as other medications*	*Codes* *-remove stigma/talk more* *-provide support* *-education* *-collaborate* *-currently in adequate help* *-not talked about*

Thematic Analysis

This section will provide detailed results from the analysis. Three emerging themes will be discussed with their 12 corresponding categories. I will discuss each theme and its subsequent categories separately. The themes and categories were used to answer the research questions for this study.

Theme 1: Insight on Mental Illness

The first theme was insight into mental illness. The theme emerged from the questions in the interview guide asking about describing mental health, how mental illness is viewed among African immigrants in faith settings, and the causes of mental illness. Categories under this theme include a definition of mental illness, causes of mental illness, cultural inferences of mental illness, and religious inferences of mental illness. The theme answers the research question regarding the experiences of African immigrants in the United States with mental health care use as well as how religion influences mental health care use as noted through religious causes of mental illness.

Definition of Mental Illness

All participants answered the question about describing mental illness. Eight participants reported that mental illness relates to "cognition, thinking, mind issues" and they felt it touched on an individual's "psychological and emotional functioning," while two participants felt they did not know much about mental illness and described it as "antisocial behavior and lunacy" of individuals. P1 described mental illness as "something that affects your emotional health" while P2 described it as "mental instability". All 10 participants mentioned in their description that there is much more

knowledge of mental illness in recent years in the media and they did not have this prior information in their countries of origin. P3 stated "I have been here for more than 2 decades, and I have only learned about mental illness in the last 3 years", P7 stated "discussions about mental health are now happening but were not as public before". Participants in the United States for less than 10 years had more deficiency in knowledge of the mental illness. P8 stated, "I am not sure what it is, isn't that more of an American term?"

Spiritual Inferences About Mental Illness

In terms of the feelings of the respondents about how African immigrants in faith settings deal with mental issues, most of the respondents stated that persons with mental issues are seen as "being demon possessed" and were looked at them as "weak Christians who do not pray or fast enough" or "had a distant relationship with God." All 10 participants stated mental illness is highly ignored in religious settings and not thought of as a real problem, P5 stated "we just ignore it and do not talk about it, hoping it goes away." Half of the participants mentioned "casting out demons and exorcism" for mental illness. P8 stated, "We pray and cast out the demons as well as have traditional rituals to remove the demons" while P3 stated "If you are mentally ill, they think you are demon-possessed. Something has come on you and you need demons to be cast out or you need prayer or performing some kind of ritual." Participants' perceptions of mental health are heavily shaped and informed by their religious affiliations and thus mental illness was considered a punishment from God for wrongdoing or a warning to do better by higher powers such as God and ancestral spirits.

Cultural Inferences of Mental Illness

Mental illness was viewed as “social misfits in society.” All 10 participants mentioned fear of being shunned away from their communities or being seen as an outcast if mental illness was revealed. P2 stated, “also I feared being cast out of the African communities and become more isolated, so I just stayed quiet”. Mental illness was also viewed as “curses from ancestral spirits” and thus needed sacrificial procedures to overturn it. P8 stated, “cast out the demons as well as have traditional rituals to remove the demons”. Others mentioned bad omens and familial spirits overtaking families. P9 stated, “mental illness is an omen. people do not talk about it. It is discriminated as a man, it is shameful, and one is seen as weak for having a mental illness, so you suffer in silence.” P10 stated, “maybe the great grandparents were not happy and sent the disease”. There was a heavy reliance on traditional cultural practices in the perceptions of mental illness as mentioned throughout by the participants. P6 mentioned, “in our culture, you do not expose the crazies, you have to talk and please the ancestral spirits,”. When asked what crazies meant, the participant stated, “mentally ill persons.” P4 also reported traditional rituals reliance in response to treatment of mental illness, despite being a Christian, he would have to perform the traditional activities with elders of the community to ensure the mental illness was removed from his family “there are other traditional rituals that can be done even with prayer”.

Causes of Mental Illness

In terms of what causes mental illness, there was an interrelation of both social and cultural/religious ideologies. All ten participants mentioned that there was spiritual

causation of mental illness and three quoted Bible verses showing that mental illness was spiritual. P3 stated, “we are a spirit, and we live in a body, so we have to deal with the spiritual things spiritually before getting to the physical things.” Other respondents felt that mental illnesses are caused by socio-economic hardships and environmental and cultural changes from immigrating to the United States though they still tied the economic hardships to religious aetiologies. P10 for example stated, “I had postpartum depression and had a lot of financial hurdles, but God allows hardships to make us stronger”. Interestingly, despite most of the participants having a bachelor’s degree and earning more than $80,000 annually, the changes in their socioeconomic status were still attributed to religious blessing rather than education. P3 stated “God has now blessed me with better health insurance” while P5 mirrored the same sentiments “now that God has given me riches and having insurance, I receive better care but without it, mediocre care is given”. Some statements for causes of mental illness were “not being religious enough” which on probing questions was clarified as “not praying enough and not attending services enough.” All participants mentioned “lack of praying” as part of the causation of mental illness. P1 mentioned she had severe anxiety from hormonal imbalance but stated she had exhausted and addressed religious causes including more prayer and fasting despite being ill before having laboratory findings to confirm hormonal imbalance. The participant still attributed the diagnosis as a religious blessing due to the biological cause rather than mental illness. “God answered my prayers and now I am healed but I still take thyroid medications.” Regarding individual experiences with mental illnesses, eight respondents stated they had not personally experienced mental illness but

described situations where "it could have been distressing." One participant stated, "maybe it was a mental illness like depression, but I wouldn't call it that because I do not want to label it." Others report divorce, domestic violence, work-related stressors, and loss of loved ones could result in a period of "feeling down" but should not be called depression as the terminology is a western term. P10 stated, "Even those who encourage you to get help tell you to speak in faith and not mention your symptoms or diagnosis so as not to make it come to you. It's an isolating season".

Theme 2: Treatment of Mental Illness

The second theme was the treatment of mental illness. The theme emerged from questions regarding how the participants thought mental illness should be treated, views of psychiatric medications, treatment for their children as well as experiences in hospitals and clinics. This theme answers the research questions regarding the experiences of African immigrants in the United States with mental health care as well as how religion influences mental health care use among African immigrants in the United States. The categories under this theme include cultural influence, religious influence, formal mental health care perceptions, experiences with the mental health care system, and stigma/shame associated with disclosing mental illness.

Cultural influence

All ten respondents mentioned that in their countries of origin, they relied on cultural measures in the treatment of mental illness. The measures mentioned are "talking to elders, seeking ancestral powers to please them," using traditional African healers as well as consuming "certain foods known to heal mental illness." Some of the traditional

practices mentioned were offering “blood from goats to the ancestors” which was mentioned by five of the participants while others mentioned traditional practices but did not feel comfortable elaborating or explaining the practices. Despite their western religious affiliations, there was an interrelation of the African traditional religious systems such as worship of ancestral spirits which were intermingled with the cultural perspectives thus difficult to delineate between the two. All the participants despite their religious faiths mentioned cultural/traditional measures as done in their countries of origin. P5 stated, “we use the blood of goats in our culture to appease the ancestors” while P4 stated, “I do not do those rituals anymore, but my family will still do it for me, I would rather pray”.

Cultural traditions are also noted to dissuade seeking formal mental health care. P8 stated when responding to treatment of mental illness, “Isn’t that American thing? people stay in America too long and start behaving like them, …. if I did, some people from my culture would alienate me and find me too westernized…,” while P9 stated in responding to seeking formal mental health care “that is not how we do it as Africans”. A post-graduate participant P10 stated, “despite being in the medical field, I never thought I could get depression as an African, we are strong, these are American diseases. But now I have changed my mind about getting it”. There was also a gender variation in mental illness treatment, as male participants mentioned their perceptions of how an African man should behave. “I am an African man, I tough it out and not cry about it” and “I am expected to be tough, hard, and emotionless.” P5 stated “I just manned up and toughed it

out. I did not seek help. It was a functional depression where you are still in public but suffering in silence”

Religious Influence

Religious practices were highly relied upon by all participants and were their first preference in dealing with mental illness. Religious practices were mentioned by all ten participants with statements like “more prayer and fasting” and “talking to spiritual leaders” being the common reoccurring theme. P1 stated “mental illness isn’t real, it's maybe demonic thing going on, and they feel like you can also just pray your way out” in response to how African immigrants viewed mental illness referring to the generalized community understanding of mental illness. P3 stated, “If you are mentally ill, they think you are demon-possessed. Something has come on you and you need demons to be cast out or you need prayer.” All participants mentioned that mental illness had spiritual inferences to it and thus they had to consult religious measures for healing. Half of the participants mentioned that “medicines cannot even work without praying first.” P5 stated “you have to engage both together. I think they work interdependently with each other. Religion can help mental wellness when they are both used together with medicine, if not, then it makes it less impactful and hinder mental wellness. Religion offers hope and a good expectation, so I think it fosters mental wellness especially when it is used in conjunction with mental health care.” P3 mirrored the same perceptions by stating “honestly, I would start with spiritual first then do medical. But that is not only mental health, it is all medical issues. God is in charge; I would not take medicine without prayer first. So, I will pray the sickness away first even with a tummy ache or headache.” The

participants inferred that prayer and fasting provided “hope” which in turn created a healthier environment where medical interventions would be successful. On experiences with mental illness, all stated a spiritual connotation of each experience such as “I would pray for them more,” “I would fast more,” and “I felt better after praying and singing worship songs.” There was no difference in opinion between Protestants, Nondenominational or Catholic participants in terms of religious influence in the treatment of mental illness. Non-denominational participants did discuss being open to collaboration between both medical and spiritual treatments whereas Protestants and Catholic participants mainly relied on prayer.

Formal Mental Health Care Perceptions

Formal mental health care was not highly regarded among participants. Eight respondents indicated that they would not seek psychiatric help as a first option if they had a mental illness. Those who were against seeking psychiatric support feared stigma and discrimination, being looked at as people who are cursed, social misfits, or possessed by demons. They also indicated that seeking formal care for mental illness was not an African thing to do. P2 stated, “so it is more of like a Western thing, more than an African thing. So, in the African culture they do not accept it hence they pressure you not to get any help and use traditional or religious things.” P3 stated “So I will pray the sickness away first” while p8 stated “No, I would not seek help, I can talk about it, pray about it. medicines also have a lot of side effects while p9 stated, “a man I am expected to be strong. Also, my nephew had mental illness and had to live in an institution for several months, it is shameful and looked down on, that is why it is hard for people to be open

about mental illness. He is good now though but still takes medications." Two of the participants who stated they would seek help from a psychologist or therapist had previous first-hand experiences with mental illness. In both cases, the participant sought formal mental health treatment after exhausting all other options but reported relief because of medical interventions. One of the two participants P2 stated "depression for ten years and it got to the place where I could no longer work" before seeking health care services. Similarly, P1 stated, "I had to go back to my home country, fast, pray and seek ancestral help before accepting help from a psychiatrist…… I did not know psychiatric help was an option for me." The other eight participants stated they would only seek medical care as last resort. Several statements such as "unless I could not get out of bed" or "was walking outside on the streets naked" were noted.

In terms of the type of formal mental health care, all participants were more comfortable with psychotherapy where they would say "therapy" or "talking" rather than seeing a psychiatrist or taking medications. P10 stated, "I can go to therapy but not to psychiatry or hospital. I feel that those areas are reserved for very sick people. It is also a little embarrassing". P6 who was against the terminology "psychotherapy" stated, "Tough it out, maybe talk if necessary but do not call it psychotherapy, why do people get too westernized? Anyway, avoid stressors. Go out and have fun and pray about it".

There was an elevated reluctance in taking psychiatric medications among the participants. Nine of the participants stated they would not take psychiatric medications. Their reasons for the reluctance were fear of side effects, fear of addiction and inability to function without the medications, and beliefs that the psychiatric medications were

different from regular medications and would permanently alter their mental functioning. P5 stated, “medications change the way one thinks” while P1 stated, “so the doctors prescribe me a bunch of stuff, and I never did take that. I was afraid maybe I would go crazy; you know, I do not trust doctors because they only patch you up.” P6 stated that “medicines only treat symptoms but not the cause of the illness” in response to reasons for not taking psychiatric medications if needed. Follow-up questions on whether participants would seek medical assistance with a physical illness all showed that all participants would readily seek medical care with or without prayer for other illnesses but not for mental illness. Psychiatric medication was also not perceived as “regular medicine”. P5 stated, “those drugs are a hit and miss, they do not specifically target the issue” while P9 stated, “the side effects are worse than the disease itself, medications for mental illness are not in the same category as other medications”, P3 stated, “I can only take the drugs for a very short time and wean myself off. I am a nurse; I know what those medications can do”. P4 believed the medications would make mental illness worse, “I think medication makes things worse, and what I’ll really try first is a certain diet to see if you can help”. Upon probing which diet was suitable for mental illness, P4 reported it was traditional green vegetables and fruits. There was also a fear that treatment could be against God’s will. P9 stated, “what if the hallucinations were God talking to you and then you take medications? It’s good to pray first”.

When asked about seeking mental health treatment for their children, there were mixed feelings with a lot of hesitation in answering the questions. P10 stated, “that is a difficult question because what would cause children to have mental illness apart from

the devil?" Six respondents paused before answering this question during the interviews and appeared uneasy. The six would not seek mental health help if their children had a mental illness to avoid discrimination, and fear of stigma on their children as well as their cultural/religious beliefs. The hindrances were thus the same as those for adults in seeking mental health care. P3 stated "I would protect my children at all costs, anything that would make them be treated differently; I would not expose it at all" while P5 stated, "speaking to a therapist would be okay but not medications, children are too delicate". Those who would not seek treatment reported they would wait it out before seeking help and would rather pray instead. Of note, the two participants who had previous experiences with mental illness and had sought help were willing to seek help if needed for their children. They both had graduate level education and earned above $80,000.

Experiences with the Mental Health Care System

Regarding the question about the experience of immigrants in the US clinics and hospitals compared to Africa, all respondents indicated that they faced racism or some sort of discrimination while attending US clinics and hospitals. Two participants who had sought mental health care, stated their experiences were negative. One stated the staff would not believe her and thought she was pretending until she revealed her profession as a medical professional. P2 reported "Once I told them who I was, then they believed my symptoms and started treating me with respect. I had to come in with my scrubs for them to treat me differently." All the participants mentioned "accents" being part of the problem in discrimination regarding accessing any kind of health care services. P2 stated "as soon as you speak, they will treat you like you do not know what you are talking

about, as if Africans are not educated" P1 stated, "They treated me like an outcast due to my accent and did not believe me". P5 stated that he was regarded as an African American until he spoke and things "quickly went from bad to worse". P8 and P9 reported they avoided hospitals due to perceived bad treatment which they attributed to their African descent as well as racism due to their skin color. P9 in response to treatment at healthcare centers, stated, "they think we are primitive and speak down to us especially when we do not have money. I think money and insurance would change how they treat you". P10 stated, "they start asking where I was from and asking if I see lions outside my home, they believe everything in the media and treat us different".

Participants also felt the American system was rushed and prescriptions were given too hurriedly. P1 reported, "I was not being believed and was being quickly prescribed medications without a thorough workup to get rid of me". P1 reported she did not take the prescribed medications. P5 also reiterated similar sentiments by stating "They just want to get rid of me waiting in a waiting room and give me a band-aid medication, so I do not trust the health system". Discrimination and stereotypes were also described by P10 "they would not give me pain medication on the second day after cesarean section. I felt they looked at me as a drug seeker, they would not have treated a white person the same". Participants also reported feeling like misfits between two countries: the country of origin and the country of residence. P1 stated "In the US, they do not expect mental illness from us, they think that we need traditional help, or we are just angry. In Africa, they think we are crazy. You do get treated differently, but like in my case, they did not take me seriously. I saw 5 different doctors before they took me

seriously". P2 reported, "In Africa, you are insane. In America, you are discriminated against. Where do you get help?"

All participants reported perceived improved care with time as socioeconomic status rose as they had better insurance policies that gave them access to a higher quality of health care. In terms of recommendations to enhance mental healthcare among African immigrants, respondents indicated that undertaking the education of people in the community and ending retrogressive culture would be important in enhancing the use of mental healthcare. P6 stated, "we need more education, more teaching, more collaboration, and financial help to foster and teach people in the churches all would help. So, the more tools we have, the more resources are available to reach more people." P3 mirrored the same sentiments:

> "I think we need to give information when people have the knowledge and they know what to do regarding where they are or how to handle this mental illness, make them aware that there are resources out there to help you, and this is how you can go about it, even if you want to do it anonymously, in case there are people who are still dragging behind because change for many people comes in different ways".

Ending racism and discrimination while creating synergies and collaborations was also reported to be equally important in supporting the uptake of mental healthcare among African immigrants. P5 stated, "If we are treated equally and there was less racism, it would be easier to seek care not just for mental illness but other things as well".

Stigma and Shame

There was noted apprehension in sharing their mental health diagnosis or treatment with religious leaders and family members. The concept of shame was mentioned by all participants where mental illness was frowned upon thus by both the religious sectors and communities. Shame and stigma were noted in both the diagnosis of mental illness, a family member having it, accepting treatment for it, or even taking psychiatric medications. P10 reported in terms of mental illness diagnosis, “It is also a little embarrassing to have mental illness” while p2 stated about her diagnosis of mental illness “I felt ashamed, scared and judged and I still do not discuss it with other African uneducated people because they still judge me”. Social maladjustment and institutionalization of mentally ill people in the countries of origin also contributed to the shame and stigma of mental illness. P6 stated, “We do not have mental illness in Africa, we do not talk about it and people with mental issues stay in an institution or live on the streets which is shameful” The component of sharing was also looked down upon due to fear of transference of the “demon possession” P5 stated “since not many people understand mental health in Africa and they will outcast you so it’s better to keep it to yourself and if you talk, it could come on the other person” when probed on what would come to the other person, P5 replied “mental illness or demons”

Of those who would seek mental health care, they would not disclose it to religious leaders especially those back in Africa. About seven stated they would disclose to the nuclear family in the U. S. but not to the family living in Africa since those living in Africa would not understand and are more likely to judge and discriminate against

them. P10 stated, “With family members, it would be really hard to share. They are still in the notion that mental illness does not affect Africans and it is a western disease or a disease of weaklings”. P6 reported it was not African to share such information “Maybe, I am not sure. No, I would not share it. It is not African to share such news. You keep it close to yourself to avoid judgment. Being sick in Africa is not viewed the same as America”. P3 reported, “because of my profession, I am comfortable discussing it, especially in American circles but not so much in African circles due to being seen as weak and deficient”. P1 stated, “In America, there is more acceptance of mental illness among whites, and they view it as a regular disease so it’s easier to share with them, we Africans still do not accept it”.

Theme 3: The Role of Religion in Mental Health Care Use

The third theme is the role of religion in mental health care use. The theme emerged from questions regarding how the participants thought religion could assist in supporting its members in mental health care use and what recommendations they would provide to facilitate African immigrants to utilize mental health care. The categories under this theme include education, normalization of mental illness, and collaboration. This theme answers the research question; How does religion influence mental health care use among African immigrants in the United States.

Education

In terms of what role religion plays in the use of mental healthcare, all participants felt that religion did not assist in mental health care use and could do more to augment mental wellness among African immigrants. Participants indicated that religion

and the church could play a key role in education in areas such as supporting the rehabilitation of individuals with mental health issues, creating awareness of causes, prevention, and treatment of mental health illnesses, and could support the management of mental health issues through the provision of psychiatric therapy. Education from the religious perspective was for both members and the leadership. P10 passionately stated,

> "Religion needs to educate its members to demystify mental illness and stop telling people its demons and aliens. Teach them about it, about mental illness symptoms. Educate the pastors. Pastors feel like they know everything, and they do not. Also, educate people that pastors are not gods, and they should stop taking their final word as the only word. Rely on both faith and medicine. Faith without works is dead"

Like p10, p3 stated, "Leaders also need to be more informed so that they can teach the members and offer more than just prayer. There is too much emphasis on only the pastors and some pastors do not know about mental health and need education too".

Most of the participants reported an increase in the last 2-3 years of more awareness of mental health in the media providing some ideas about mental health. P3 stated, "This is also new. In the last 2 years, they have started talking about mental illness in the media but not so much in the churches." P5 stated, "I think information is key. When we lack information, we would perish, we do not have a lot of information. Yeah, I think that is where we need to start from knowledge and empowerment empowering our immigrants."

P8 stated she only learned about mental illness in the last two months, “I have only now started to learn more about it, I need more information”. All participants purported that mental health was not discussed as much as they feel it should be in religious settings such as the churches and most of their information was from the media outlets P4 stated, “the churches are getting more versed with mental health though not as much as it needs to.”

Religion among African immigrants was also noted to be a multifaced factor since, despite the modern religious affiliations, most participants had traditional religious beliefs intermixed with cultural beliefs regarding their perspective of life, wholeness, and mental health. P7 stated, “I still need to be part of my culture so I cannot abandon my African traditions and adapt only western beliefs” when questioned on the role of their traditional religious beliefs versus their modern religious affiliations, the participants stated they both work together as their families in Africa still rely on traditional faith. P10 stated, “I do not believe in them anymore, but my parents do so they pray and also offer sacrifices, education is needed even in Africa” while p4 stated, “but my family in Africa do not accept mental illness, they think it is spiritual and that you have a demon and will perform rituals to cast out the demons or to make ancestors happy, while I prefer to pray”. As a result, mental well-being among African immigrants was noted as a multifaceted issue that could not be addressed through brick-and-mortar buildings but also through traditional faiths as well as modern medicine. All participants stated that religious affiliations should provide more education to their congregants regarding mental health through education of signs and symptoms to ensure people recognize mental

illness and seek treatment. P5 reported, “maybe pastors should have mental health as part of seminary courses to make sure the preachers know about it since most preachers do not have sufficient information so they cannot guide us”.

On the question of whether pressure from religion would influence mental health use, all respondents stated if their spiritual leaders talked about mental health and there was more acceptance, they would be more likely to embrace and seek mental health care. P3 stated regarding seeking mental health care and disclosing it to the religious leaders “Yes, I would share with them as well, but it depends on whether they openly discuss mental health. if they do, then it is easy to talk to them if not then it is harder, and they cannot give me counsel.” P6 stated, “if my pastor encouraged me to seek mental healthcare, then I would do it, but they do not talk about it”, while P4 reported, “If there was less stigma in the church and mental illness was accepted, I would be more comfortable seeking help”.

Collaboration

On the question regarding the role of religion in mental health care use, all ten participants mentioned the need for collaborative efforts between health care and religion to foster mental health care use. P3, P5, and P10 mentioned the phrase “Jesus and therapy” which upon probing referred to collaborative efforts between therapists to the church and making mental health counseling a part of religious activities. P3 stated, “creating avenues for members to seek mental health, counselors, integrate care ministries in the church like Sunday school classes so we can normalize mental health”. P7 reiterated that “psychiatrists, therapists, and religious leaders should all come together

and learn from each other to make it a better place." Collaboration was also used to mean financial support to the religious organizations to improve the outreach and awareness programs. P6 stated' "more collaboration, financial help to foster and teach people in the churches all would help. So, the more tools we have, the more resources we offer, the better".

All participants voiced that religion was preventing mental health care use among the African immigrants. P2 stated, "In Catholicism, there is no space for that…. I feel that it is never addressed, and no help is available for those needing help. The bishop and priests should talk about it, and they should stop blaming people or calling them weak for being mentally ill. It would really help," while p1 stated:

> "religion stigmatized people and prevents people from seeking help and I feel like a lot of people have actually lost their lives, too, because they cannot talk, because if you speak out, some like I said will say something is wrong with you, some demons, or not praying enough, you're not close to God enough and it shouldn't be happening to you, and they have all kind of scripture to back it up. So, the church should take charge and start raising people, to understand that these things are real, and people do need help. Both psychologists and medicine can help."

Participants also voiced that seeking formal mental health care would not be fully adequate without religious activities such as prayer. P1 stated, "so both faith and medicine because God comes first use both collaborations absolutely for that education to occur" while P2 stated, "we need to be talking about it because talking can increase education in the churches. Education is looked upon in Africa and is very highly respected so if that

individual or those individuals start creating awareness by talking about it there will be more awareness and collaboration with the church and mental health.” P1 stated that “as much as I can take medication for mental illness, my faith comes first, so there needs to be collaboration for both mental health and the church”. P5 stated “You have to engage both together. I think they work interdependently with each other. Religion can help mental wellness when they are both used together, if not then it makes it less impactful and hinders mental health, Religion offers hope and a good expectation, so I think it fosters mental wellness especially when it is used in conjunction with mental health care.” P10 also had similar thoughts and stated, “Rely on both faith and medicine. Faith without works is dead”.

Normalization

All 10 participants mentioned that mental health should be talked about more to reduce the stigma and discrimination in their communities when dealing with mental health. Statements such as p5 stating “they would call me a lunatic if I disclosed my mental illness” or “mentally ill people are institutionalized in Africa hence we have to hide it” reflect the participants feeling that they need to hide mental illness to avoid the shame associated with it. Hearing statements such as “you are not close enough to God if you suffer from depression” as reported by P8 also reflect the participants’ feeling that they were not part of the religious community due to their suffering from mental health issues. P10 stated the same regarding depression as “a disease of weaklings” thus isolating the sick individual from the very support needed at that time. P10 thus stated “why can’t we just talk about depression and anxiety in the church, it exists but it’s all hush hush” with p8 reiterating similar perceptions, “the church feels like they own your

whole entity, you cannot even feel depressed because then you are weak”. All participants vocalized that “talking about mental health more” would help not only educate but reduce the stigma associated with mental illness. P3 stated, “we need to make it normal like any other disease so that it is more acceptable” P5 stated that since their religious leader had discussed mental illness, he was much more accepting of it as a disease. The concept of mental illness not being a real disease among African Immigrants in religious settings also emerged. One participant stated, “nobody views this as a real disease”, another stated “it’s not like a stroke or a headache”, and still another stated, “Jesus cursed demons from that child, it’s not as real as they say”. Mental illness is thus labeled as an anomaly in the religious settings with far in-between cases known making it a secretive disease to deal with.

Evidence of Trustworthiness

As described in chapter 3, I set out to ensure that there was dependability, credibility, confirmability, and transferability to enhance trustworthiness in the study. Burkholder et al. (2016) state that a researcher’s commitment to the above factors can ensure trustworthiness in research.

Credibility

Credibility ensures that the study is transparent and believable, and that the data collected informs the study (Lueng, 2015). To ensure credibility in the study, I used member checking and triangulation. Member checking was done by providing transcripts from the audio recording to the participants to ensure that their experiences were fully captured as they intended. All participants returned the transcripts and validated their

portrayal of their perceptions. Triangulation in data collection was also utilized in ensuring multiple approaches to answering the research questions such as audiotaping, journal notes, and observation.

Transferability

Transferability is the extent to which the study can be generalized (Burkholder et al. (2016). Despite the sample size being small at ten participants, I provided a detailed in-depth description of the demographics, the number of participants, duration of the interviews, and data collection period which enables readers to identify the limitations of the study that would affect transferability (FitzPatrick, 2019) The participant pool was also varied from different parts of Africa; West, East, and South which provided a variation in the study sample with varying experiences and backgrounds ensuring a rich comparison of data and thus increasing transferability.

Dependability

Dependability is a component of trustworthiness that ensure that data stays unchanging over time thus ensuring consistency (Elo et al., 2015). Triangulation in data collection through audiotaping, journal notes, and observation provided consistency in the data collected. Coding of the data both manually and through Dedoose also ensured the consistency of the analysis. Digital audio recordings also keep the data available over time and were stored on a personal password-protected computer.

Confirmability

Confirmability ensures that researchers can verify the study and have confidence in qualitative research based on data rather than the researcher's opinions (Ravitch &

Carl, 2016). Confirmability was maintained in the study by maintaining a reflexivity journal to record my own opinions, and biases throughout the process to ensure I remained objective.

Summary

This chapter described the data collection process and study sample, presented the results of the thematic analysis, and provided evidence of trustworthiness. After recruiting the participants via purposive sampling, I then conducted 10 interviews. All interviews were audio recorded and transcribed. I reviewed transcripts for errors and did member checking to ensure accuracy as well as to ensure the data answered the two research questions. After coding, I developed three themes with 12 categories which assisted in understanding the role of religion in mental health care use among African immigrants in the United States. All participants had a vague understanding of what mental illness was and reported the knowledge had been enhanced in the last few years due to heavy portrayal of mental health in the media but had varied causes of mental illness. There was a heavy reliance on religiosity on the causes of mental illness such as demon possession, prayerlessness, sin et cetera. Treatment of mental illness was also religiously based on prayer, song as well as African traditions such as pleasing ordinances to ancestors. Psychiatric medication was highly frowned on as well seeking mental healthcare unless as a last resort with combined religious activities. In the role of religion in mental health care use, religion was found to be lacking in fostering mental health care use though participants stated there needed to be more collaborative efforts from the religious leaders as well as medical professionals in making mental health care

more easily accessible. Racism, as well as indifference in the health care setting, arose especially when the participants spoke out and their “accents” were noted. The treatment was noted to improve with increased socioeconomic status. More education to create more mental health normalcy would likely reduce the stigma and shame associated with mental illness as well as collaboration was a common recommendation provided by the participants in the study. Chapter 5 will provide a discussion of the connection between the literature categories and themes derived from chapter 4. Chapter 5 will also provide an interpretation of the results, implications for practice, and limitations of the findings as well as provide recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this ethnographic qualitative study was to provide an explorative understanding of how religion influences mental health care use among African immigrants in the United States. Ten individuals living in the United States, from various African countries participated in semistructured interviews where they shared their experiences with the mental health care system in the United States and discussed how religion influences mental health care use. Five interviews were done via Zoom while the other five done in person. There were no major differences between the interviews, but I noticed the in-person interviews lasted longer and participants were more eager to have a more conversational discussion compared to the Zoom interviews. This could be likely from feeling more comfortable in person than through the Zoom platform. I used thematic analysis to search for similarities and differences within the data which was used to answer the research questions. I then chose commonly reoccurring ideas and summarized them in a few words as my codes. The codes were then grouped into categories based on their commonalities and then I grouped and organized the categories into three themes that answer the research questions and were framed by TPB. Three themes and twelve categories emerged to answer the research questions and to fill the gap in the literature on how religion influences mental health care use among African immigrants in the United States.

The key findings of the study were in the three themes: insight into mental illness, treatment of mental illness, and the role of religion. There was a heavy reliance on religion in both the interpretation of mental illness and the treatment of a mental illness

which provided a hindrance to mental healthcare use. Religion was not just the brick-and-mortar affiliation but also traditional practices which impacted the perception of the participants regarding the diagnosis of mental illness and treatment. All participants reported that they felt, at the current time, that religion was hindering mental health care use due to a lack of normalization of mental illness in their respective denominations as well as in their African communities. The ongoing media education on mental health awareness was providing some education but there would be more acceptance if their churches accepted mental illness. The religious leaders were also found to be very influential on decisions about seeking mental health care. This chapter will provide an interpretation of the findings, limitations of the study, recommendations, implications, and finally, provide a conclusion for the study.

Interpretation of The Findings

This section describes how the findings from the study confirm, disconfirm, or extended the current knowledge as noted in Chapter 2 of the literature review. The section will also provide an interpretation of the study and analysis according to the theory of planned behavior. Three themes were identified in the analysis with their subsequent categories are outlined in Figure 3.

Figure 3

Organization of Themes and Categories

1.Theme:Insight on mental illness	1.Theme:Treatment of mental illness	1.Theme:Role of religion in Mental illness
• Categories • 1. Causes of mental illness • 2.Definitions of mental illness • 3.Cultural inferences of mental illness • 4.Religious inferences of mental illness	• Categories • 1.Cultural healing practices • 2.Religious healing practices • 3.Stigma and shame • 4.Formal mental health perceptions. • 5.Experiences with mental health care system	• Categories • 1.Education • 2.Collaboration • 3.Normalization

In Chapter 2, the literature review, the themes noted were religion, mental health perceptions, acculturation, mental health care use, and stigma. The results of my study confirmed similar themes/categories as shown above with insight into mental illness, treatment of mental illness, and the role of religion as the overarching themes that emerged from the study. The findings of this study provided meaningful connections identified by the participant's experiences regarding how religion impacts mental health and mental health care use in the United States. Data from the literature review in Chapter 2 showed that religion played a role in mental health care use but did not elaborate or define what role it plays. MHA (2020) stated that about 90% of the Black population in the United States reported that religion influences their health and wellness. My study confirmed findings to be accurate even among African immigrants. The results

of my study also described how religion influences mental health care use thus extending previous research.

In this ethnographic study, the cultural views of 10 African immigrant participants were explored to better understand their experiences as it pertains to the role of religion in mental health care use. The study was designed to answer the following research questions:

RQ1: What are the experiences of African immigrants in the United States with mental health care use?

RQ2: How does religion influence mental health care use among African immigrants in the United States?

I used TBP in this current study to understand mental health care use among African immigrants in the United States as it pertains to the role religion plays in health behaviors. I will thus discuss the emerging themes with corresponding research questions to further interpret the results of the study.

Theme 1: Insight on Mental Illness

This theme answered the research question of how religion influences mental health care use among African immigrants in the United States. Religion is found to influence the insight on mental health among African immigrants in the United States. The first theme is insight on mental illness which has four categories: causes of mental illness, definitions of mental illness, cultural inferences, and religious inferences on the insight of mental illness. The theme covered how participants viewed mental health as African immigrants in the United States, how they thought it should be treated, and what

caused mental illness. This theme also covered any experiences participants had previously had with mental illness to determine the extent of the knowledge they had in recognizing mental illness.

All participants answered the questions describing what they believed mental illness was and the consensus was that mental illness was any illness involving the brain and thinking capacity. P2 stated "I think it is anything that affects how one thinks or emotions, diseases of the mind." P3 described mental illness as diseases that affect mental status., P5 stated,

> To me like the word suggests it means it is something that affects your mental well-being, your psychological world, maybe which means the state of your mind is how you think how you socialize and how you act, it's actually a state that affects your emotional health. when I think of mental illness, I think of people walking in the streets naked and do not make sense.

All participants mentioned their developing knowledge surrounding mental health due in the past 2-3 years due to more publicity in the media regarding mental illness as well as several participants' own experiences with mental illness thus being more cognizant of mental illness. One participant stated, "I never thought I could get depression as an African, we are strong, these are American diseases. But now I have changed my mind about it." Other participants mentioned, "I have only learned about mental illness in the last 3 years", and "discussions about mental health are now happening but were not as public before". Mental illness definition thus changed as there was more exposure and education in the media as well as firsthand experiences with the disease. The findings

thus confirm observations in Chapter 2 that discussed mental illness as understudied among African immigrants and was not considered an actual disease but rather a "silent crisis" (see Ojikutu et al., 2018). It also extended the current knowledge in showing that with the current increase in mental health awareness in the media, more people were becoming aware and developing some knowledge of mental wellness.

All participants also answered the questions regarding the cause of mental illness where there were varied answers. The responses regarding the causes of mental illness discovered were also consistent with the literature review of previous studies but with the more added knowledge of how unresolved trauma and stressors can lead to mental illness. Participants reported stressors such as divorce, financial hurdles, illness, and death as contributing factors to mental illness. The stressors and trauma were however attributed to influence from higher powers such as God and ancestral spirits showing the influence religion had in their interpretation of life events. One participant attributed both mental illness and economic hardship to the will of God, "I had postpartum depression and had a lot of financial hurdles, but God allows hardships to make us stronger", still another participant stated in response to the causes of mental illness, "weak Christians who do not pray or fast enough get mentally ill". The overwhelming cause was thus from the religious and cultural perspectives such as demons, evil spirits, and ancestral powers which were mentioned by all participants, consistent with Chapter 2 literature review showing that human inadequacies, spells, curses, and demonic spirits were attributed as the causes of mental illnesses among African immigrants (see Agbemenu, 2016; Habecker, 2017; Ludwig & Reed, 2016). Agbemenu (2016), for example, reported that

mental illness was described to be a result of human inadequacies such as wrongdoing while Habecker (2017) noted beliefs of familial curses as some of the cause of mental illness.

To assess their knowledge of mental health, I asked each participant about their individual experiences with mental illness where most stated they had not experienced mental illness but had seen persons in their African countries institutionalized with mental illness or walking on the streets. The view of mental illness was thus of severe cases of abandoned persons on the streets and institutionalized individuals. The overwhelming sense was that a mentally ill person could not live a normal life in society. One participant stated, “my nephew had mental illness and had to live in an institution for several months, it’s shameful” while another reporting “We do not have mental illness in Africa, we do not talk about it and people with mental issues stay in an institution or live on the streets which are shameful” showing the connotation mental illness with the severity of disease thus institutionalization or living on the streets. The views are consistent with the knowledge gained from prior literature in Chapter 2 where mental illness is viewed as an institutionalized disease or hidden to avoid shame.

Habecker (2017) reported that immigrants are less likely to abandon their religious and cultural beliefs and thus their former years in their countries of origin influence their views and perceptions in their new countries. This would explain the view of mental illness as institutionalization or not an “African disease” despite being in a different environment. There was difficulty noted in acceptance of mental illness diagnosis among those diagnosed. Statements such as, “maybe I felt low, but I would not

use the word depression, that is too strong a word" while the other one said, "I never thought I could get depression as an African, we are strong, these are American diseases." The participants who had experienced mental illness reported denial in accepting the diagnosis or treatment for a long time. One stated, "I had depression for 10 years and it was until I could no longer function that I accepted treatment". The aspect and difficulty of accepting the diagnosis as well as only viewing it from a perspective of severity thus institutionalization add knowledge to current literature.

However, as the literature review revealed, the more enculturated the individuals become, the better their health outcomes become in their new country according to Shoup et al. (2020). My study results showed that with time the immigrants acknowledged mental illness and accepted formal help without institutionalization. The participants also expressed more acceptance of mental illness in America and thus they were more inclined to share their experiences with nonimmigrant Americans rather than with their African families as they did not receive rejection or shame. P6 stated "because of my profession, I am comfortable discussing it, especially in American circles but not so much in African circles due to being seen as weak and deficient". This is consistent with an appraisal of beliefs in the theory of planned behavior where if the appraisal is positive (no judgment or shame), then behavior engagement is more likely (seeking mental health care).

This theme is consistent with the TPB which posits that attitudes toward a behavior include their behavioral beliefs (see Asare, 2015). Behavioral beliefs are the concepts and ideologies that a person has that inform and guide their decision-making

capabilities (Asare, 2015). The perception or insight on mental illness is the beliefs they hold about what mental illness is, how it is recognized, and how it should be treated. Erroneous beliefs lead to erroneous behavioral intentions and thus inform decisions (Vaismoradi et al., 2016). In this case, when mental illness is identified as caused by evil spirits, curses, weak Christian living, or offending ancestral spirits, the treatment will be geared towards overcoming the aforementioned factors rather than seeking medical care. Consequently, formal medical care is of limited use in such a belief system since religion, whether religious affiliations or traditional religious activities, govern their care. The theme is reinforced by previous research as well noting that the behavioral beliefs among African immigrants would need to be addressed from the religious perspective which they heavily rely on before formal mental health education (see Adu-Boahene et al., 2017; Echeverria-Estrada & Batalova, 2019; Ekwonye et al., 2021).

Theme 2: Treatment of Mental Illness

The second theme was the treatment of a mental illness which arose from the questions about feelings about seeking mental health care, how mental illness should be treated, whether the participants would seek mental health care for themselves or their families, and views on taking psychiatric medications or seeing psychiatrists. Religion again was found to influence the views on the treatment of mental illness based on their interpretation of mental illness from a religious perspective. The experiences with the mental health system in the United States are also explored in this section to understand their lived experiences with the healthcare system. This theme answers the research

question regarding the experiences of African immigrants in the United States with mental health care use.

Regarding feelings about seeking mental health care, there was elevated negative connotation in seeking health care where participants preferred religious activities such as prayer and fasting rather than medical care. Traditional rituals were also mentioned several times as a remedy to combat mental illness. Traditional rituals and religion went hand in hand without differentiation between the two indicating that African immigrants, despite having modern religious affiliations, still considered traditional rituals as part of their religion. Religion was noted to be a major support in coping with mental illness even among those who would consult formal mental health services. The participants believed that religion augmented formal medical care and thus undertaking medical care without religious support would yield ineffective results. These observations confirmed previous studies that noted that African immigrants heavily rely on religion for overall wellness, support, coping, and focus on life (see Adekeye et al., 2014; Olokotun et al., 2019; Omenka et al., 2020). Seeking mental health care was also viewed as weak and a Western behavior that Africans should not embrace, a concept noted in this study that extended current knowledge on the subject. Those that would seek mental health care for themselves, or their children stated they would not share the information with their African families due to fear of stigmatization, shame, being shunned in their communities as well as discrimination in their personal and religious circles. The findings mirror those of Olokotun et al. (2019) who noted that even among educated parents who would seek mental health care for their children, they were less likely to disclose such information to

African immigrants' communities from the perceived shame of having a mentally ill child as well as isolation from their communities that were their support system.

Stigma and shame were also noted in correlation to seeking formal mental health services. Consistent with Nantwi et al. (2017), mental illness was to be dealt with in silence and alone until it was gone. The word "isolation" was used by more than half of the participants in describing how to deal with a mental illness meaning that one was to keep it private and suffer in silence without involving the community. Stigma and shame would resort to loss of community support and the value of community support among African immigrants cannot be understated. The participants voiced their silence and decisions not to seek mental health care if needed to avoid being shunned away from their communities. As discovered in Chapter 2, their religious circles provided support and were their focus of life (Omenka et al., 2020). Having community support is an important aspect of the theory of planned behavior subjective norms. The study provided more insight into the facilitation and interaction of social support and their decision-making capacities. The participants would choose to have social interaction which was perceived as support rather than share a mental illness diagnosis that would result in shunning from the communities thus a perceived lack of social support. Their decision-making capacities were thus influenced by the perceived behavioral control which is the ease of difficulty associated with performing a certain behavior according to the TPB. Their religious beliefs thus show that religion plays a role in delaying and impeding mental health care use.

There was also a lack of knowledge in the religious circles as it relates to mental health and its treatment. All participants stated they did not hear of mental health in their religious institutions and only gained knowledge in mainstream media in the last few years. Interestingly, almost all participants mentioned that if their religious leaders would mention and talk about mental health, they would be conversant in sharing and accepting mental health services. One of the participants mentioned that they were more accepting of mental illness since their leader had discussed it in church but would not have otherwise accepted it. The findings in the current study are consistent with Agyekum and Newbold (2016) and Nantwi et al. (2017) where the role of religious leaders was explored as an essential element with African immigrants in health-seeking behaviors and those religious leaders had a paramount influence on the decision-making of the congregation. The study thus provides insight into how religious leaders may use their influence to increase mental health care use.

Regarding experiences with the health care system, this study confirmed previous findings of lack of use of mental health services until the disease was severe. Ludwig and Reed (2016) also noted perceived overdiagnosis as an issue which was confirmed in this study. Also, this study expanded on a different concept where medications were prescribed without much testing to "get rid of the patient" thus extending current knowledge. The participants felt "ignored" and "not understood" by healthcare providers resulting in visiting multiple doctors or stating their professional qualifications to get the necessary assistance. The views of misunderstanding are consistent with NAMI (2021) where cultural competence in health care systems was low with the incomprehension of

accents and lack of cultural awareness of African immigrants. NAMI (2021) reports that the black population is more likely to use physical symptoms to describe mental health issues thus a provider unfamiliar with this phenomenon is likely to misdiagnose or misunderstand the patients if they do not probe for further information. This phenomenon was noted when participants preferred to say sadness rather than depression as well as the perception that hallucinations were not necessarily a negative symptom as it could be God speaking to them. Being aware of the description of these symptoms would consequently be essential for providers to understand when treating African immigrants.

Racism and discrimination were also an issue in the healthcare system as well as disparities in care where the type of medical insurance and location of the clinic dictated the quality of treatment received by staff in the healthcare system. Accents were a major focus in access to treatment where the immigrants felt ignored, stereotyped as primitive, and treated differently due to their ethnicity and accents. The experiences are consistent with the TPB where perceived behavioral control is the ease or difficulty in performing a certain behavior. The experiences created difficulty in mental health care use which in hand resulted in reduced mental health care use. Asare (2015) states that decreasing barriers to care such as reduced racism, and reduced language barriers can thus increase in the ease of performing a behavior. Reducing these barriers can therefore reduce the increased difficulties and reluctance in mental health care use and would hopefully be beneficial in easing the opportunities for seeking mental healthcare to willing individuals.

Fears of psychiatric medication was also noted which was a new theme not noted in the literature review. Participants stated they were more comfortable if needed in

therapy though they preferred to call it “talking to someone” rather than using “psychotherapy” which was a more medical term that would result in labeling and likely referring to they needed help. Fear and hesitancy were also noted in medical diagnoses where calling depression “feelings of feeling down” but not calling it depression was preferred. Psychiatric medications were referred to as “different categories” “had more side effects” addictive” and “worse than the disease itself.” This view was consistent among all participants including those who had sought medical care for mental illness but refused the medications or weaned themselves off after a few days due to fear of “side effects” or “feeling worse”. Despite the fear of psychotropics not being noted in the literature review, it could be related to the findings of Freeland et al. (2020) that African immigrants felt western healthcare providers over diagnosed patients and thus prescribed more medications compared to African countries. This hence led to hesitancy and mistrust in taking prescribed medications.

Asare (2015) reports that attitudes towards behavior in the TPB influence every aspect of the behavior and thus affect the outcomes. In this case, the attitude or fear was likely due to the skewed view of mental illness, its causes, and treatment which inadvertently created qualms of the medications. Statements like “what if God was talking to me and I took medications” further strengthened the causation of mental illness thus treatment could interfere with their religious views. Of interest, the medication uncertainty did not extend to other medications where on probing questions, participants would readily take other medications for other diseases but not for mental illness. Changing the attitude towards mental illness causations could thus change the attitude

towards mental health care use which would include acceptance of the diagnosis and treatment using various psychiatric mental health care plans.

Vaismoradi et al. (2016), report that social pressures or subjective norms in a society influence performance of behavior where if the community supports the behavior, there would be more acceptance of the behavior. When there is a higher acceptance of medications in the African immigrant community, there would more likely be more mental health care use and acceptance of treatment modalities prescribed. Increasing acceptance could be a result of increased education in the community regarding the mode of action of the medications thus demystifying the common ideologies regarding psychotropics. Monnapola-Mazabane et al. (2021) reiterate that when the appraisal is positive, engagement of the behavior would also be more likely.

Although an increased level of education is often correlated to increased health care use, education did not seem to change or alter the perceptions of mental health care use or causation in this study (Fan et al., 2020). All participants in the study supported these perceptions regardless of education level. Their education level and subsequently increased socioeconomic status as shown on demographic data regarding income levels were also attributed to a religious blessing rather than a rise in the socio-economic ladder from their educations and consequently better jobs. This reflection further supports the efficacy of religion as the lens to every aspect of the African immigrant's life including wellness which is consistent with previous studies (see Ekwonye et al., 2021; MHA, 2020; Nantwi et al., 2017; Omenka et al., 2020; Saasa, 2019; Ting & Panchanadeswaran, 2016; Wharton et al., 2018).

Theme 3: The Role of Religion in Mental Health Care Use

The third theme was the role of religion in mental health use which included three categories: education, collaboration, and normalization of mental illness. The theme arose from questions regarding how religion should support mental health care use as well as recommendations for African immigrants in dealing with mental illness. The role of religion in mental health care use among the participants was in educating the members, collaborating with other organizations to deliver care in religious settings, and reducing stigma through the normalization of mental illness. This theme answered the research question regarding the role of religion in mental health care use among African immigrants in the United States. All participants indicated that more education was needed regarding mental illness. Interestingly despite their education levels, they reiterated that education was needed in their religious settings to demystify the current notion of mental illness being a curse, inadequacy, being weak, being un-African et cetera. The participants felt that if education came from the pulpit, then they were more likely to not only accept mental illness as any other disease but also likely to engage in mental health care usage. The findings augmented the literature review finding that religious leaders' panegyrization of mental health could influence their behavioral beliefs, which in turn could increase the perceived behavioral control to perform the intended behavior (Lefevor et al., 2020). The findings also expand on available literature that despite higher levels of education among African immigrants, religious teaching had a greater influence on mental health beliefs and behaviors.

The role of religion was identified currently in this study to be inhibiting mental health care use through ignorance of mental illness as well as skewed perspectives. However, despite knowing that there were medical causes of mental illness, there was a noted need to include the religious causes of mental illness and report the need for collaborative efforts between religion and mental health care organizations. The concept of only medical care was seen as deficient by the participants but when collaborated with spiritual care, it was synergistic towards wellness and wholeness. The realization of this knowledge extends the current data on the need to have collaborative efforts between religion and health for effective health education among African immigrants. TPB discusses behavioral intention as the true extent of performing behaviors when resources and skills needed are available (LaMorte, 2019). The collaboration of health care and religion would increase behavioral intention and thus increase mental health care use. Education was not only needed for African immigrants but also for the African immigrant clergy who have a propensity to lead the African immigrant faith institutions (Sackey-Ansah, 2021)

More than half of the participants discussed the need for their spiritual leaders to be more versed in mental wellness. The leaders were thus seen as the main barrier as their normalization of mental illness would not only reduce stigma and acceptance but also increase the use of the services. The observations of the study in participants stating that their religious leaders did not speak of mental health were consistent with Payne and Hays (2016) study showing that religious leaders felt ill-equipped in handling mental illness and thus did not discuss it or discussed it very seldom with one sermon a year

being an average. The lack of normalization through open discussion of mental health by religious leaders potentially creates a barrier in mental health care use thus reducing perceived behavioral control. Perceived behavioral control consequently dictates that mental health/illness is a complicated issue to deal with among the congregation leading to further isolation, shame, and stigma of mental illness. With the normalization of mental illness, the ease of accessing or discussing mental health issues would increase. African immigrants would hence be more likely to access and use mental health care services as noted in this study where the participants voiced they would be more amenable to seeking help if the religious leaders talked about it.

Normalization of mental illness was mentioned by all participants in discussing how religion should support its members with mental illness. According to the theory of planned behavior, removing barriers in performing a behavior is more likely to increase the behavioral intention towards the behavior (LaMorte, 2019). In the normalization of mental illness, associated stigma, discrimination, and feelings of being weak and inadequate would be reduced thus increasing the ease of not only discussing mental illness but also use of mental health care services. Having mental health discussions within families and religious groups/institutions which are noted as the support system for African immigrants (Ekwonye et al., 2021; Omenka et al., 2021) would thus promote mental health care use. Previous research however showed that the more acculturated an individual was, the more likely they were to adopt health-seeking behaviors (Habecker, 2017). Despite most of the participants being in the United States for at least two decades, they still preserved their immigrant country's perception of mental health with

heavy reliance on religion to interpret it for them. Ekwonye et al. (2021) noted that there was also identity confusion between assimilation into American culture versus maintenance of their African cultures where immigrants felt too "African" to be called African Americans yet too "American" to be regarded as African. Habecker (2017) explained that despite multiple years of immigration, some immigrants did not leave their cultural or religious beliefs, especially among first-generation immigrants who composed all the participants in this current study thus explaining the retention of immigrant country perception of mental illness. The need for health care providers to be conversant with the African culture and retention of cultural/religious beliefs among African immigrants is of utmost importance despite the length of time spent in the immigrant country, to deliver optimal health care.

Limitations of the Study

This study had some limitations. The sample size was small with a limited number of participants. Despite 10 participants being adequate for the qualitative study with noted data saturation, the sample remains too small to generalize the study findings to all African immigrants in the United States thus reducing the transferability of the study results to the general population. Purposive sampling also created a limitation since all participants had to fit the inclusion criteria thus there was a lack of random sample to create a more diverse outlook such as those who did not speak English or those who were older who may have had varied experiences. The study would have also benefitted from being broader to cover other locations and States thus giving more diversity and generalization. An additional limitation was that the study did not have any north African

participants and thus may not reflect the experiences from immigrants from northern Africa. As a result, interpretations cannot be generalized to North African immigrants that may not only have different religions but may also have different experiences. Another potential limitation was the length of time the immigrants had been within the United States and how that impacted how religion influenced mental healthcare use since the participants reported their outlook on mental illness had just recently changed in the recent years despite most having been in the country for more than a decade.

Recommendations

The study can be used as a baseline for future research to launch more studies in which the identified roles of religion can be utilized to increase mental health care use among African immigrants. Future qualitative and quantitative research can also be done with a larger sample including all geographic parts of Africa to gain more transferability and generalization of the study results. Future research could also examine the role of socioeconomic status on mental health care use among African immigrants since it is associated with improved healthcare access (Fan et al., 2020). More studies on different religious affiliation roles in influencing mental health care use to gain a deeper understanding of how modernization on religion affects health care use.

In public health practice, having collaborative efforts between mental health providers and African immigrant religious institutions would provide firsthand information and cultural competency to providers, the clergy as well as the congregation thus improving mental health among African immigrants in the United States. Cultural competence among providers should also be improved and expanded for providers and

public health officials working with African immigrants to provide holistic centered care to the population. In faith-based institutions, the normalization of mental health and illness by the clergy can be encouraged by fostering conversations through having trained faith-based therapists offering their services in the faith-based institutions thus creating a synergy between religion and mental health. Adding educational requirements for faith-based leaders within the African immigrant population on the topic of mental illness can be also important to demystify mental illness thus making them more likely to not only discuss mental wellness in the faith-based institutions but also making collaboration with mental health care organizations more feasible. Inclusion of religiosity in African immigrants' treatment plans among providers is essential while gathering data as their wellness is attributed to their religiosity.

Implications

This study has contributed to filling the gap in the literature regarding the role of religion in mental health use among African immigrants. On the individual level, the study implications have resulted in more mental health discussions with African immigrants thus beginning the much-needed conversations about mental health among study participants and their families which reduces barriers such as stigma associated with mental illness (Omenka et al., 2020). On the organizational level, more information is provided on African immigrant culture and religious views which creates cultural awareness. Cultural awareness can lead to cultural understanding among the care providers treating African immigrants thus creating a positive social change through improved health outcomes among the African immigrants as well as the increased

perception among the providers. The study findings increase more data on African immigrants in the United States that can be shared with health providers, clergy members, mental health providers, teachers et cetera. Sharing of the data can expand cultural knowledge on African immigrant health not only in health care but also in schools, and faith-based institutions thus providing more awareness of the experiences of African immigrants with mental health which contribute to a positive social change in rising mental health education level. Wharton et al (2018) report that increased awareness of the mental illness and stigma associated with mental illness demystifies the disease thus increasing wellness among those who suffer from it. The information gained in this research can also inform policymakers in mental health care as well as religious settings about the need for collaborative efforts between religion and healthcare. Endeavors such as inviting mental health providers to speak in churches or religious leaders to speak in mental health clinics promote cooperation and increase knowledge hence creating a positive social change for not only the providers and the clergy but also African immigrants seeking mental health care from increased education. Gained knowledge in this study also increases the database on African immigrant health and serves as a continued unveiling platform for further qualitative and quantitative studies among African immigrants in the United States.

Conclusion

I embarked on a study to understand the role of religion in mental health use among African immigrants in the United States. This was an ethnographic qualitative study that aimed and achieved to understand the experiences of African immigrants in the

United States health care systems as well as an understanding of how religion influenced their mental health care use. NAMI (2021) reports that one in five adults suffers mental illness every year in the United States and ADAA (2022) reports that the leading cause of disability worldwide is mental health illness. With the African immigrant population doubling every decade since 1970 (U.S. Census Bureau, 2020), Adu-Boahene (2017) states that there is increased underutilization of mental health care among African immigrants. There is a lack of mental health literacy among African immigrants as mental illness is not discussed nor treated in African communities unless very severe (Omenka et al., 2020). The results of this study suggest that mental illness is attributed to curses, omens, evil spirit/demon possession, inadequacies in religious living et cetera with little connection to the hormonal or physiological causes of mental illness. The study findings identified religion as a barrier to mental health care use due to erroneous interpretation of the perception of mental illness, its treatment, an overall lack of discussion of mental health among religious leaders or members, increased stigma, and the increased discrimination associated with mental illness in religious circles. Mental illness is thus not accepted as a disease and is often ignored in religious settings with a focus on more prayer, fasting, righteous living, or traditional rituals rather than formal treatment. The study identified that religious institutions, as well as religious leaders, can play a role in educating their members, collaborating with mental health organizations as well as normalizing mental illness to create more awareness. The role of religion is thus education, demystifying mental illness, and normalizing mental health care.

The study has implications for positive social change in increasing awareness, cultural sensitivity, and education, as well as invoking discussions around mental health among African immigrant communities. Each participant was not only eager to voice their need for more education but also more acceptance of mental health when embraced by religious leaders. This study was designed with the goal of providing empirical data that can be used to inform continued mental health discussions with religious leaders and mental health providers. Increased awareness and education on mental wellness would improve the overall health and wellness of African immigrants in the United States which can improve health care use. This study shows that it is thus critical to understand cultural and religious views when seeking to address mental health needs among African immigrants' populations which would in turn improve the use of mental health services.

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Appendix A: Recruiting Flyer

If you

- ❖ Are above 18 years old
- ❖ Immigrated from Africa to USA as an adult
- ❖ Are a legal immigrant in the US
- ❖ Have lived in the US for at least 3 years
- ❖ Can speak English
- ❖ Live in Houston

You are invited to participate in a research study to explore the role of religion in mental health care utilization among African immigrants in the US. The study will be conducted for Mary Nganga's Walden University dissertation as part of her requirements to earn a doctorate in Public Health. The study will involve face to face interviews lasting 60 minutes with an option available for virtual interviews due to covid 19 pandemic.

If interested, please email Mary Nganga at mary.nganga1@waldenu.edu with date and time availability.

Appendix B: Interview Guide

1. How would you describe mental illness?

2. Tell me your feelings about how African immigrants in faith settings deal with mental health issues?

3. What do you think causes mental illness?

4. Tell me about a personal involvement you have experienced regarding mental illness.

5. As an African immigrant, how do you feel about seeking mental health care from psychiatrists, therapists, or hospitals?

6. How do you think mental illness should be treated?

7. What role do you think religion plays in mental health?

8. If you had a mental illness, would you seek psychiatric help? Why or why not?

9. If your child had mental illness, would you seek mental health help? Why or why not? Would you share that information with other family members? why or why not?

10. In what ways would religious pressure or pressures from family or friends impact your decision to seek mental health care?

11. How would you feel sharing your mental health diagnosis or treatment with your religious leaders and family members?

12. What are your views on taking psychiatric medications prescribed to help with mental health issues?

13. How do you think religion can assist in supporting its members in the use of mental health care?

14. What is your experience as an immigrant in the United States clinics or hospitals compared to Africa?

15. Any closing thoughts or recommendations you would choose to give regarding mental healthcare use among African immigrants?

Appendix C: Demographic Survey

1. What is your age
    a) 18-29 years old
    b) 30-39 years old
    c) 40-49 years old
    d) 50-59 years old
    e) 60 -69 years old
    f) Over 70 years old
2. What is the geographic location of your country of origin?
    a) East Africa
    b) West Africa
    c) South Africa
    d) North Africa
    e) Central Africa
3. How many years have you lived in the United States?
    a) 3-10 years
    b) 11-20 years
    c) 21-30 years
    d) Above 31 years
4. Income level
    a) $0-$40,000 per year
    b) $40,000-$80,000 per year
    c) Above $80,0000
    d) Prefer not to disclose
5. Education level
    a) High school
    b) Some college
    c) Undergraduate degree
    d) Graduate degree
    e) Postgraduate degree
6. Religious affiliation
    a) Christian
    b) Islam
    c) African traditional religion
    d) Prefer not to disclose
    e) Other_________________