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Exploring the Relationship Between Spirituality and Mental Health among Kenyans Living in the United States: A Review of Literature

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EXPORING THE RELATIONSHIP BETWEEN SPIRITUALITY AND MENTAL HEALTH AMONG KENYANS LIVING IN THE UNITED STATES: A REVIEW OF LITERATURE

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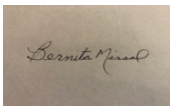
Project Advisor Signature: 

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Abstract for Critical Review of Literature

Background: The increased stigma of mental health in the African population is a major barrier to seeking care. Nurses need to understand the influence of culture and spirituality in caring for this population.

Purpose: The purpose of this critical review is to if there is a relationship between mental health and spirituality in a Kenyan population living in the United States.

Results: The review consisted of 16 articles. The major findings were divided into 3 areas: mental health and Africa, mental health and spirituality, and spirituality and Africans. The major themes include stigma, lack of resources, immigration, religion and mental health, and spirituality and mental health, and religion and mental health. Stigma, lack of resources, and immigration were identified as barriers to seeking care. Spirituality was linked to the etiology of mental health through cultural beliefs. Religion provided specific coping strategies through social support, prayer, and meditation.

Conclusion: The research indicated a link between mental health and spirituality in an African population. Stigma and lack of resources lead to this population living with mental health disorders in secret. As a group, immigrants are predisposed mental disorders. Africans are more likely to seek care from spiritual leaders due to the etiology of mental illness.

Implications for Research and Practice: Madeleine Leininger's transcultural nursing theory provides a framework for nurses in practice. Nurses need to be aware of cultural beliefs of mental health care in order to provider appropriate interventions.

Keywords: mental health, mental illness, faith, religion, spirituality, culture, Nigeria, South Africa, Uganda, Ethiopia, Africa, African cultural groups, Kenya

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Chapter 1: Introduction

Mental illness is a prevalent condition that affects millions of people daily from a variety of cultural and socioeconomic backgrounds. Due to the stigma of mental illness in Kenya, many do not seek treatment; they instead opt to live in secret in fear of their reputation within the community (Anglero, 2018). According to Dr. Kanyoro (n.d.), "at least one in every four Kenyans suffer from mental illness" and there are few trained mental health professionals to meet the needs of the population (para. 1).

Statement of Purpose

A shared belief in Kenya is that mental illness is a result of evil spirits (Anglero, 2018). "It is not unusual…for patients to look for alternate explanations to mental illness given stigma, strongly held traditional beliefs, and limited access to psychiatric care and psychoeducation" (Anglero, 2018, p. 7). It is important to investigate if spirituality influences mental health outcomes in this population. What is the relationship between spirituality and mental health in the Kenyan population living in the United States?

Evidence

Historically, mental illness was viewed as a source of religious punishment or demonic possession. This belief led to a social stigma and consequently institutionalization in unhealthy conditions. This endured until the 1840s when Dorothea Dix advocated for better conditions driven by the poor conditions she witnessed in the confinement of the mentally ill (United for Sight, 2015). The stigmatization of mental illness still exists in today's society fueled by learned behaviors and the media portraying the mentally ill as either dangerous or just choosing to behave a certain way. Often, families from cultural backgrounds will hide any evidence of mental illness in the hope of avoiding negative attitudes and views towards them from the public

eye. This stigma leads to resistance in seeking help from the appropriate sources to treat or support those suffering from mental illness; it can also lead to an escalation of the illness to the point of a crisis.

A research review by Ndetei et al. (2016) found that there is little investigation on mental health stigma in the Kenyan population as well as a lack of knowledge by Kenyans on mental illness. Another article by Dr. Kanyoro (n.d.), a lecturer and Clinical Psychiatrist, found that many Kenyans suffer in silence due to the stigma, and generally believe that mental illness is related to witchcraft or spiritual concerns. Based on the historical view of mental illness, it is important to investigate and understand the relationship that exits between spirituality and culture when mental illness is concerned.

Significance to Nursing

Mental health is a part of providing holistic care to patients. According to Happell (2020), "mental health skills, expertise and positive attitudes are essential for the message of holistic nursing practice" (p. 42). Patients suffering from mental health disorders need the same level of quality care other patients receive. They need compassion, empathy, and sensitivity to meet better health outcomes. Often, negative attitudes towards mental health care can work as a deterrent to seeking a career in mental health. It is important for nurses to assess their attitudes and biases towards mental health disorders as an initial step to providing care for this group of patients.

Theoretical framework

The transcultural nursing theory, also known as cultural care theory, was developed by Madeleine Leininger (Kanchana & Sangamesh, 2016). According to the article, transcultural nursing is "a comparative study of cultures to understand similarities (culture universal) and

difference[s]" with the goal of providing culturally competent care (para. 2). This theory has three steps to attain cultural competency: 1) adopt attitudes such as caring, openness, empathy, and flexibility, 2) "develop awareness for cultural difference," and 3) conduct a cultural assessment while being aware of family structure to compile mutual goals with the patient (paras. 3-5).

One of the major concepts of this culture, which Leininger defines as a set of practices and beliefs that are held by a specific group (Current Nursing, 2012). Culture shock is another concept defined as "the state of being disoriented or unable to respond to a different cultural environment because of its sudden strangeness, unfamiliarity, and incompatibility" (para. 31). Culture shock can lead to feelings of discomfort due to the inability to adapt to the strange environment. Leininger believes that cultural competence is an important part of nursing in order to provide care to patients. In addition, nurses need to be aware that patients from a diverse cultural background may not gravitate towards western interventions. Traditional practices and religious beliefs may need to be integrated to ensure improved health outcomes.

Summary

Historically, the mentally ill have been viewed as dangerous or unpredictable. Mental health stigma in Kenya has not been well researched. An additional barrier to seeking care include lack of knowledge on mental illnesses. This is due to a general belief that mental illness is caused by witchcraft or spirits. Nurses need to have cultural competence to provide mental health care to patients from a diverse background. This process includes assessing personal attitudes and biases towards mental health disorders. Leininger's transcultural nursing theory can be used as a framework to provide holistic care to Kenyan patients.

Chapter 2: Methods

The initial search of articles investigating spirituality and mental health in a Kenyan population yielded few articles. Four additional African countries were added to the literature review to strengthen. Religion as a key word was later added to the search strategies to yield more results. In total, 16 articles were used in the literature review.

Search Strategies

A broad literature review of quantitative, qualitative, and opinion articles was done using CINAHL and PsychINFO databases. Key search words include mental health, mental illness, faith, religion, spirituality, culture, Nigeria, South Africa, Uganda, Ethiopia, Africa, African cultural groups, and Kenya. Literature reviews discussing mental health stigma, the role of religion, and diverse culture will be included in the literature review.

There were 16 studies that were relevant to the purpose of this study. The results of the studies were organized into three categories: mental health and Africa, spirituality and mental health, and Africans and spirituality. Due to an inadequate article result on only the Kenyan population, the search was expanded to include four additional countries. These countries were chosen because they were among the top ten African countries reporting a high case number of reported depressive disorders: Nigeria (7.1 million), Ethiopia (4.4 million), South Africa (2.4 million), Kenya (2 million), and Uganda (1.7million) (World Health Organization, 2017). Inclusion criteria for article selection includes the following:

- Publication year 2000-2019
- Peer reviewed articles
- Articles in the English language
- Qualitative and quantitative studies

Articles that included an African American population and traditional healer practices were excluded from the study.

Criteria for Evaluating Research Studies

The articles in this review were evaluated using the Johns Hopkins Nursing Evidence-Based Practice Model (JHNEBPM) (Dang & Dearholt, 2018) to determine and level and quality of the article reviewed. Majority of the articles used for the review were rated a level III due to their non-experimental and qualitative nature, while level V was used for non-research-based articles that were literature reviews. The quality rating identifies the consistency of results and amount of evidence found in each study.

Summary

The articles search was performed in three stages due to the lack of research articles on mental health, spirituality, and African groups as combined key words. Various key words were paired to yield the studies found for this critical review. Finally, each article was reviewed using the JHNEBPM and rated on the level and quality based on the results. The matrix method was by Gerrard was used to summarize each article and can be seen in Table One.

Chapter 3: Literature Review and Analysis

The matrix of literature (Table 1.1) presented several themes in mental health, spirituality, and Africans. Stigma, lack of resources and trained mental health professionals, lack of knowledge, and trauma were the main themes in Africans and mental health articles. In articles discussing spirituality and mental health, themes of coping through religious practices were consistent. Finally, in spirituality and Africans, themes of a believe and reliance in God were found.

Synthesis of Major Findings

Mental Health and Africa

Getanda et al. (2017) examined mental health in children using community stakeholders and found four themes: "economic challenges and lack of resources, limited mental health knowledge and lack of culturally appropriate interventions, stigma, and systemic issues" (p. 203). Poverty was identified as a socioeconomic factor that contributed to poor mental health outcomes and accessibility issues. In addition to lack of knowledge, often the interventions used were those based on a western population that did not take cultural differences into account. The systemic issues oftentimes reside at the family level in that parents are not aware of predictors for mental health issues in children, and they are not aware of interventions for the family as a unit. Stigma was associated with negative help-seeking behaviour and social exclusion.

A case study by Anglero (2018) on a Kenyan youth explored the role of stigma on mental health seeking behaviour. This article found that stigma played a large role and often acted as a deterrent to seeking care for family members. Often, stigma comes with prejudice and stereotypes that can lead to ostracization from the community. Families are reluctant to seek care because they do not want to gain a negative reputation. In the article, the youth shared that

stigma prevented her from sharing her true feelings of sadness, guilt, and hopelessness with her mother. Another finding of the article was that the perceived etiology of mental health was evil spirits. A study within the case by Anglero (2018) found general themes of danger and unpredictability when it came to views of the mentally ill.

In Uganda, a study by Ager et al. (2012) explored the mental health of humanitarian aid workers who had experienced multiple traumatic events. A survey was conducted of 376 staff with 61% reporting that they were exposed to secondary trauma by frequently listening to stories about trauma. In addition, 53% scored at or above the anxiety and 68% scored at or above the depression subscales of the Hopkins Symptom checklist.

Another study on Uganda and mental health care by Akol et al. (2018) explored the willingness of traditional healers to collaborate with contemporary mental health professionals. Traditional healers are often sought out for help in part because of beliefs about the cause of mental health illness. Akol et al. (2018) found that traditional healers believed mental illness was a result of unhappy ancestral spirits or evil presence. Other views included jealousy brought on by other people in the community due to prosperity, sometimes viewed as the evil eye. Another important finding from this qualitative study was that traditional healers were willing to collaborate with clinicians because they had the common goal of trying to alleviate the mental health symptoms to patients.

A literature review by Lasebikan (2016) explored the cultural aspects of mental health in Nigeria. One of the studies in the review found that mental illness was a form of punishment that required spiritualists for healing. This view is somewhat similar to other African countries. In addition, most Nigerians are more likely to neglect care due the stigma from the community and the general view that the mentally ill are dangerous. An interesting finding in the literature

review is that some Christian Nigerians are not willing to use medication to treat medical conditions, but will instead rely on prayers for healing. This becomes challenging for mental health professionals who need to prescribe medications for certain conditions. In general, the study found that a high level of cultural competence was necessary for providing effective and accurate mental health care to a diverse population of patients.

A study by Vergunst (2018) sought to explore the current state of mental health care in rural South Africa and found that there is a general lack of mental health care. Transportation issues were among the leading barriers to accessing care. This was mainly because if referrals were given, it meant travelling to another city to seek care. In addition, the use of medication was viewed more as a western intervention and might not be as effective for the South African population. Interestingly, there was a general lack of medical professionals to prescribe medications, meaning the task was often left to mental health nurses.

Alemu (2014) performed a study to explore the cause of mental health illness among Ethiopian students. Of the 370 students surveyed, only 28.33% viewed mental illness as a prevalent health condition. In terms of the cause of mental illness, there was a gender discrepancy with 31.2% of female students attributing it to supernatural causes compared to 23.3% of male students. This view holds similar to that of other African countries.

Mental Health and Spirituality

A study by Kovess-Masfety et al. (2017) surveyed religious guides in 21 different countries to explore their role in mental health care. Of the population surveyed, 1.1% reported using religious provider services for mental health help. The study found that 20.6% of the respondents from low/lower-middle income countries sought care for a severe disorder compared to the 12.3% from upper-middle income countries and 9.5% from high-income countries. As an

example, 41.6% of the most severe cases in Nigeria (low-income country) were treated by religious advisors. Certain characteristics in respondents indicated a higher likelihood of seeking religious advisors for mental health care. These include younger age, marital status of separated or widowed, attending religious services more than once a month, seeking comfort in religion during difficult times, and living in certain countries. In general, there was a trust in religion when seeking comfort for the challenges brought by mental illness.

Pandya (2018) performed a study to review the role of spirituality and spiritual education in providing support for mental health to refugees in Europe. The participants were surveyed twice: once before the spiritual education program started and again after the program ended. Pretest trauma scores were 8.01 while post tests revealed a reduction to 5.89 using the trauma screening questionnaire (TSQ)…based on items from the PTSD Symptom Scale – Self Report…the life orientation test-revised (LOT-R)…the mental health inventory – 38 (MHI-38)" (p. 1398). The results indicated that spiritual services introduced coping mechanisms that helped improve the mental health outcomes of refugees. Other predictors of mental health included "voluntary participation, full attendance, and self-practice willingness" for positive outcomes (Pandya, 2018, p. 1402).

A study by Petts (2018) explored the relationship between miscarriage and mental health with religious participation as a moderator. The study found that women who experienced a miscarriage and a live birth within the same year were more likely to report low mental health outcomes. Women who experienced a miscarriage but attended religious services reported significantly higher mental health outcomes; this suggests that religion could provide some level of protection to improve mental health outcomes. Religious participation provides factors like social support and resources to develop coping mechanisms. The study indicates that religion

could be an important aspect of coping after the loss of a pregnancy.

Keyes and Reitzes (2007) investigated if religious identity explained a difference in self-esteem and depression in older working and retired adults. This study found that as "self-esteem increased and depression symptoms decrease as religious identity increased" (Keyes & Reitzes, 2007, p. 438). Therefore, religious identity is a noteworthy predictor of mental health.

A study by Jang et al. (2018) surveyed children in Nepal who had survived an earthquake. The study's aim was to verify whether a relationship exists between mental health and religion through the frequency of prayer. The group with a low daily prayer frequency correlated with high levels of anxiety and depression, increased somatic symptoms, and internalization of symptoms.

AbdAleati et al. (2016) performed a systematic review on religion and mental health. It was found that religious participation in a formal setting is associated with opposing results in mental health symptoms of anxiety and depression. Some specific practices were implied to decrease suicide rates and substance abuse. A major finding of the study is that spiritual practices can help individuals form goals and cope better with anxiety and depression.

Spirituality and Africans

A scoping review by Omenka et al. (2020) discussed the theme of spirituality as it relates to health status in immigrant Africans. The reviewed used Arksey and O'Malley's Scoping Review framework to research a topic that has not been well studied. The study is the first of a scoping review on immigrant Africans in the United States. The review found that health outcomes were not predicted by the ability of providers to treat the conditions, but rather by God. Therefore, some illness, such as cancer, were viewed either to be curable or not based on the will of God. In addition, Western medicine was viewed as too reliant on physical problems and

negligent on spirituality as it relates to health. Finally, the attendance of religious service was a crucial piece of coping with challenging life and health issues.

Bakibinga et al. (2014) investigated the role of religion in coping with job stress. The study interviewed female nurses who were actively religious and found that their faith helped them mange and cope with the stress of work. The nurses felt that the calling to the profession was from God, the opportunity to serve others on a day to day basis was related to Christianity, and the challenges of work were often overcome through certain coping mechanisms. Among these were prayer, meditation, religious service attendance, and support through social circles.

Simmelink et al. (2013) explored the health beliefs and practices of East African refugees living in the United States. The qualitative study found that health prevention was guided by tradition and religious practices. Specifically, some religions had prohibitions on smoking, drinking, drug use, and sexual practices. Participants coped with illness through activities such as prayer and religious reading to reduce anxiety and stress. In addition, there was a trust in God because health and illness were ultimately determined by faith. Mental illness was believed to be healed through prayer from religious leaders. Finally, members in the community were more likely to use treatment services if they were validated by another community member.

Strengths and Weakness of Most Salient Studies

Mental Health and Africa

A major limitation of the study by Getanda et al. (2017) is that the sample used was from a rural setting. In addition, the participants had a potential bias, which was to portray positivity for their community. The participants overrepresented the challenges of mental health even though the focus group was designed to examine only the strengths and challenges of addressing mental health needs. The study by Anglero (2018) reinforced that stigma can have a negative

effect on mental health; however, there was only one case reviewed in the qualitative study. Ager et al. (2012) found a significant difference in gender on reported symptoms of anxiety and depression with men reporting fewer symptoms compared to women. On the other hand, the study relied on self-reporting and no clinical interviews were conducted; therefore, no clinical diagnoses could be established. The interviews performed for the study by Akol et. al (2018) were translated from Lumasaaba and Luganda to English, therefore leaving a potential for bias in the coder and transcriber's interpretation of the data.

Mental Health and Spirituality

A major strength of the survey by Kovess-Masfety et al. (2017) is that it supports previous studies that concluded that religious leaders in Africa were important within the population. A limitation of the study is that the religious survey focused on organized religion and excluded spirituality. The study by Pandya (2018) contributed new findings to the existing literature and reinforced the notion that refugees are intrinsically driven to make a difference in their lives. Limitations included the type of study; it was not randomized or controlled and the education program was designed for a majority of Muslim refugees. There were several limitations in the study by Petts (2018). The sample of women was young, mental health inventory was only asked in some waves of the interviews, and there wasn't enough information on the actual participation process to conclude that participation aided in coping mechanism. A strength of the study by Keyes and Reitzes (2007) is that it found that religious identity better predicts self-esteem and depression in retirees compared to older working adults. However, because religious identity was added late in the data collection process, causality or consequence cannot be confirmed in relation to mental health. The study by Jang et al. (2018) also made one discovery that contradicted past research: an occurrence of a natural disaster does not necessarily

lead to people becoming more dependent on religion. The limitations of the study revolve around the age of the participants. Children are often viewed as immature and lack perceived importance in religious practices.

Spirituality and Africans

Omenka et al. (2020) noted that this study was the first scoping review to examine the healthcare needs of this immigrant population. However, studies that were conducted in other languages aside from English, as well as those on refugee populations, were excluded from the review. The study by Bakibinga et al. (2014) ultimately reinforces previous studies that showed that religion helped individuals cope with stressful situations. However, the sample used was limited to one gender (female) and the interviews were translated from Luganda to English, therefore indicating potential bias. The study by Simmelink et al. (2013) was limited in the sample size, while the scope was exploratory in nature.

Summary

Stigma, lack of resources, and lack of knowledge are the major themes in mental health and Africans. Stigma creates a negative stereotype for those living with a mental illness and drives them to live in secret. In African countries, the lack of resources and trained mental health professionals contributes to a barrier in seeking care. In addition, most Africans do not have enough knowledge to identify or understand mental illness and are therefore unlikely to seek care. Finally, Africans are more likely to seek care from a spiritual leader due to the belief that mental illness is caused by witchcraft or is linked to a spiritual cause.

The results showed a link between mental health and spirituality in that spirituality provides a means to cope with the stress of mental illness. Participants that were involved in a religion had access to a social support group and used prayer and meditation to cope with the

stressful situations of life.

Spirituality is important to Africans. There is a general belief God is in ultimate control of health outcomes. Faith and spiritual practices provide guidance to better manage the health and sickness spectrum. Immigrants rely on cultural practices and beliefs to help cope with illness.

Table 1.1
Matrix of Literature

Source: CINAHL Complete Anglero, D. Y. (2018). Case presentation: Mental health stigma and the effect on children in Kenya. *Brown University Child & Adolescent Behavior Letter, 34*(11), 1–7. https://doi-org.ezproxy.bethel.edu/10.1002/cbl.30333			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: Explore the effects of stigma on mental health in one case of a Kenyan youth. **Sample/Setting:** 10-year old Kenyan girl complaining of unexpected weakness and gait change at Shoe4Africa Children's Hospital in Kenya**.** **Johns Hopkins Evidence Appraisal** **Level of Evidence:** V **Quality:** B	Two child and adolescent psychiatrists and two child psychologists conducted a psychiatric evaluation of the mother and daughter. The consult was conducted in a local dialect (not Swahili or English), with a nursing student acting as the interpreter. The pair were interviewed together and separately.	Stigma plays a large role in how a child with mental health challenges is treated, therefore leading to underreporting due to fear of ostracization. Once the youth was receptive to education and therapy, symptoms improved and so did physical presentation of the symptoms. **Conclusion:** Education and training of Kenyan medical professions can help reduce the stigma to mental illness and improve the outcomes of Kenyans by meeting their health needs.	**Strengths:** Review of stigma and its effect on mental health. **Limitations:** Article had a review of only one case.
Author Recommendations: Research the premise that mental health stigma is greater in developing countries compared to developed ones.			
Implications: Explore the role of education and training of mental health practitioners and the effect it has on meeting the mental health needs in a Kenyan population.			

Source: CINAHL Complete

Ager A, Pasha E, Yu G, Duke T, Eriksson C, & Cardozo BL. (2012). Stress, mental health, and burnout in national humanitarian aid workers in Gulu, northern Uganda. *Journal of Traumatic Stress, 25*(6), 713–720. https://doi-org.ezproxy.bethel.edu/10.1002/jts.21764

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To examine the mental health of humanitarian aid workers that have experienced five or more traumatic events. **Sample/Setting:** 376 staff from 24 organizations in Uganda. **Johns Hopkins Evidence Appraisal** **Level of Evidence:** III **Quality:** B	A 50-minute self-administered survey in English under the supervision of trained facilitators. "The Hopkins Symptom Checklist was used to measure depression and anxiety; The Los Angles Symptom Checklist was used to determine…symptoms…of PTSD;" the Maslach Burnout Index Human Services Survey was used to measure burnout (p. 715).	Three chronic stressors were frequently mentioned: economic hardships, workload, tensions between the treatment of international and national workers. 61% of the participants indicated they were exposed to secondary trauma by frequently listening to stories about trauma. 53% and 68% scored at or above the anxiety and depression subscales of the Hopkins Symptom checklist. Gender predicted a significant difference in depression and anxiety symptoms with men reporting fewer symptoms than women. **Conclusion:** National workers in humanitarian work are experiencing high levels of symptoms and unfavorable mental health outcomes. Women reported higher levels of symptoms for anxiety, depression, and emotional exhaustion.	**Strengths:** Gender differences established. Increased exposure to chronic stress was associated with unfavorable outcomes in mental health. **Limitations:** Associations could be found but causations cannot be established. The study relied on self-reporting, no clinical interviews were conducted; therefore clinical diagnosis cannot be established.

Author Recommendations: Longitudinal studies are required to further understand the variables

Implications:
Relevance in researching support for staff well-being through stress management.

***Source:** CINAHL Complete
Akol, A., Moland, K. M., Babirye, J. N., & Engebretsen, I. M. S. (2018). "We are like co-wives": Traditional healers' views on collaborating with the formal Child and Adolescent Mental Health System in Uganda. *BMC Health Services Research, 18*(1), N.PAG. https://doi-org.ezproxy.bethel.edu/10.1186/s12913-018-3063-4

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To survey the views of traditional healers in their willingness to collaborate with a contemporary health system to close the gap of care for access to child and adolescent mental health services. **Sample/Setting:** 20 traditional healers in Uganda with a mean age of 53, six of which were female, with all but one having experience with child and adolescent mental illness. **Johns Hopkins Evidence Appraisal** **Level of Evidence:** III **Quality:** B	45 minutes interviews that were conducted by a research assistant with experience in qualitative research. The interviews were in Lumasaaba and Luganda, the local languages. The interviews were then transcribed into English by the same interviewer that conducted the interview.	Two themes: "treating mental health is cultural and mistrust hamper collaboration" (p. 4). The mistrust is further divided into two categories of "willingness to collaborate and barriers to collaboration" (p. 4). Mental illness is perceived as unhappy clan spirits trying to interfere with the lives of living people because old traditions and rituals have been abandoned. Other versions include jealousy as a motivation to interfere with a prosperous individual or family. The only way to rectify this is through traditional healing. **Conclusion:** The theory of mental illness in children and adolescents are shared by traditional healers, they have limited interactions with the contemporary medical system, and there is a general mistrust in the contemporary health system.	**Strengths:** The sample size was adequate to conclude that the views found were shared all traditional healers. Also, the interviews were conducted in the traditional healers' place of work by a non-medical interviewer, therefore allowing a free expression of views. **Limitations:** Contemporary clinicians' views were not explored for the purpose of proving traditional healers' perspectives. Also, the translation of the interviews into English might have potentially created a bias in the coder and transcriber's interpreted data.

Author Recommendations: There is a need to explore strategies for collaboration between traditional healers and the contemporary health system.

Implications: There is potential for improved access to mental health services for children and adolescents through the collaboration of traditional healers and contemporary healthcare professionals.

Source: CINAHL Complete

Lasebikan, V. O. (2016). Cultural aspects of mental health and mental health service delivery with a focus on Nigeria within a global community. *Mental Health, Religion & Culture, 19*(4), 323–338. https://doi-org.ezproxy.bethel.edu/10.1080/13674676.2016.1180672

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To analyze mental health and culture in Nigerian population in the context of a global community. **Sample/Setting:** None **Johns Hopkins Evidence Appraisal** **Level of Evidence:** V **Quality:** C	Subsections of culture with the following topics: mental disorder labels, the prevalence of mental disorders, family and mental disorders, seeking treatment, mental health services, immigration, contemporary clinicians,	The "cultural interpretation of mental illness…are important determinants of treatment or help-seeking, coping strategies, social support, pathway to care, and types of services sought" (p. 325). Mental disorders are viewed as a form of punishment and spiritualists are sought for treatment. In the US, cultural minorities are less likely to identify and seek help for mental illness symptoms. Stigma creates a barrier for seeking services. Refugees were found to have a higher rate of mental illnesses. **Conclusion:** There is a common view of the origin of mental health disorders that is held in Nigeria and other African countries. Spirituality and the family act as a form of support for coping with mental disorders.	**Strengths:** Cultural competence is necessary for providing mental health care to a diverse population of patients. **Limitations:** None found – this seemed more like a literature review.
Author Recommendations:			

Integrate alternative medicine with contemporary health care to meet the mental needs.
Implications: Develop services that are driven by policy to meet the needs of a population with a vast variety of cultural differences.

Source: CINAHL Complete Vergunst, R. (2018). From global-to-local: Rural mental health in South Africa. *Global Health Action, 11*(1), 1. https://doi-org.ezproxy.bethel.edu/10.1080/16549716.2017.1413916			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To explore the state of rural mental health care in South Africa **Sample/Setting:** None **Johns Hopkins Evidence Appraisal** **Level of Evidence:** V **Quality:** C	The research is divided into some subsections: defining rural health, exploring rural health, and exploring rural mental health care in South Africa.	A lack of mental health services were found in the exploration. Transportation issues were involved when referrals were given to seek mental health care, because the nearest services were a city away. There is a general lack of training of medical professionals. The use of medication may be as effective when intervening because this is primarily a western health care model. **Conclusion:** Due to the lack of properly trained staff, the western contemporary model of addressing mental health needs cannot be solely relied on in a rural South African setting	**Strengths:** None found. **Limitations:** There was a general theme of lack of funding or no research

Author Recommendations: Further studies are needed to explore the "current status and dynamics of rural mental health in South Africa" (p. 5).
Implications: This article can hopefully initiate a discussion on the mental health needs of rural South Africa due to the lack of research in this population.

Source: PychINFO

Alemu, Y. (2014). Perceived causes of mental health problems and help-seeking behavior among university students in Ethiopia. *International Journal for the Advancement of Counselling*, *36*(2), 219–228. https://doi-org.ezproxy.bethel.edu/10.1007/s10447-013-9203-y

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To explore the cause of mental health issues and trends in seeking professional care as perceived by Ethiopian university students. **Sample/Setting:** 370 students from four random universities in Ethiopia **Johns Hopkins Evidence Appraisal** **Level of Evidence:** III **Quality:** B	A survey was used to explore the major objectives of the study: knowledge and severity of mental health issues, causes of mental health, and attitudes towards seeking care.	Schizophrenia was viewed as a mental health disorder by 86.2% of the participants, while 71.2% recognized depression and 48.6% saw anxiety as mental health disorders. Only 28.33% perceived mental health on its own as a pervasive health condition. More than 87% of the students felt that mental health disorders were caused by psychosocial elements. **Conclusion:** Majority of the students that participated in the study were able to recognize major mental health disorders and have positive attitudes toward seeking care professionally.	**Strengths:** None mentioned **Limitations:** None mentioned

Author Recommendations: Suggest future studies to explore quantitative and qualitative approaches to counseling in Ethiopia.
Implications: The study helped guide the new counseling programs established at the University where the students participated.

Source: CINAHL Complete Getanda, E. M., Vostanis, P., & O'Reilly, M. (2017). Exploring the challenges of meeting child mental health needs through community engagement in Kenya. *Child & Adolescent Mental Health*, *22*(4), 201–208. https://doi-org.ezproxy.bethel.edu/10.1111/camh.12233			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To examine the view of community stakeholders in meeting the mental health needs of children and adolescents. **Sample/Setting:** A group consisting of seven children, seven parents, nine teachers, and eleven community leaders in Nakuru County, Kenya. **Johns Hopkins Evidence Appraisal** **Level of Evidence:** III **Quality:** A	There were four focus group discussions that were conducted in English or Swahili in an open forum of questions centered on mental health needs and interventions. Data collection was guided by the absence of new information and transparency across all focused groups.	Four major themes emerged from the qualitative study: • Economic challenges and lack of resources • Limited mental health knowledge and lack of culturally appropriate interventions • Stigma • Systemic issues **Conclusion:** The improvement of mental health issues in children requires community engagement.	**Strengths:** The findings of the study were consistent with the other studies done on low and middle income countries. **Limitations:** The sample of stakeholders was taken from a specific culture and socioeconomic status group. Using a sample from rural areas could yield different results. Potential bias from the participants trying to seem positive for their community. Finally, questions were focused on both strengths and challenges to mental health needs

			but the challenges were over represented.

Author Recommendations:
Future quantitative studies are needed using a larger sample to understand help-seeking behaviours. In addition, using a sample size from a rural location may also yield a difference in themes and findings.

Implications:
The findings will be useful to policy makers as they implement planning and intervention services in communities that help children facing mental health challenges.

Source: CINAHL Complete
Kovess-Masfety, V., Evans-Lacko, S., Williams, D., Andrade, L., Benjet, C., Ten Have, M., Wardenaar, K., Karam, E., Bruffaerts, R., Abdumalik, J., Haro Abad, J., Florescu, S., Wu, B., Jonge, P., Altwaijri, Y., Hinkov, H., Kawakami, N., Caldas-de-Almeida, J., Bromet, E., & Girolamo, G. (2017). The role of religious advisors in mental health care in the World Mental Health surveys. *Social Psychiatry & Psychiatric Epidemiology, 52*(3), 353–367. https://doi-org.ezproxy.bethel.edu/10.1007/s00127-016-1290-8

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To survey the role of religious guides in mental health care. **Sample/Setting:** 101,258 adults interviewed in 21 countries including Nigeria and South Africa **Johns Hopkins Evidence Appraisal** **Level of Evidence:** III **Quality:**	A Composite International Diagnostic Interview was conducted. The questions were translated to the local languages of the countries.	Utilization of religious services was as follows: 1.1% of the population consulted a religious advisor for mental health. 20.6% of low and lower middle income, 12.6% of upper middle income, and 9.5% of high income countries sought care for severe disorders. Examples, 41.6% of the most severe cases in Nigeria were treated by religious advisors. Other general findings that correlated with a likelihood of seeking religious care for mental health included younger age, widowed or separated participants, and those that attended religious services more than once a month.	**Strengths:** The results indicated a generalized view of the importance of religion in Africa, which is consistent with past studies. **Limitations:** Religious survey questions focused on organized religion and excluded spirituality.

A		**Conclusion:** There is a general trust in religion when seeking comfort for the challenges mental health disorders bring.	
Author Recommendations: Further studies on the services that religious leaders provide for mental health in a cultural context.			
Implications: Religious advisors need training to provide interventions and collaborate with the appropriate mental health providers as additional resources.			

Source: CINAHL Complete Pandya, S. P. (2018). Spirituality for Mental Health and Well-Being of Adult Refugees in Europe. *Journal of Immigrant & Minority Health, 20*(6), 1396–1403. https://doi-org.ezproxy.bethel.edu/10.1007/s10903-018-0717-6			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To review the role of spirituality and a spiritual education program (SEP) in providing support for mental health to refugees. **Sample/Setting:** 4504 refugees in 38 camps in 9 countries (African countries represented: Eritrea, Somalia). **Johns Hopkins Evidence Appraisal** **Level of Evidence:** II **Quality:** B	Pre-test interviews and a posttest interview following the 6 day SEP package. Languages included Arabic and English. 3 scales were used to gather information: "the trauma screening questionnaire (TSQ)…based on items from the PTSD Symptom Scale – Self Report…the life orientation test-revised (LOT-R)…the mental health inventory – 38 (MHI-38)" (p. 1398).	Pre-test trauma score was 8.01 while post test revealed a reduction to 5.89. The results indicate that spiritual services introduce coping mechanisms that can improve mental health in refugees. **Conclusion:** Refugees that participated in the SEP indicated better mental health outcomes with the introduction of coping strategies. Gender differences were noted in that men intrinsically driven to be resilient to mental health issues, but are also less likely to report any symptoms.	**Strengths:** Reinforced the notion that refugees are intrinsically driven to make a difference in their lives. **Limitations:** This study was neither randomized nor controlled. The SEP could have been designed for a more diverse population but majority of the refugees were Muslim.

Author Recommendations: This study provides a good basis to understand the role of religion in refugee mental health outcomes. Further studies can take into account other variables, including any time lag between interventions provided and the type of refugee camps included.			
Implications: Interventions are needed to provide better mental health outcomes for refugees.			

Source: PychINFO Petts, R. J. (2018). Miscarriage, religious participation, and mental health. *Journal for the Scientific Study of Religion*, *57*(1), 109–122. https://doi-org.ezproxy.bethel.edu/10.1111/jssr.12500			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To explore the relationship between miscarriage and mental health with religious participation as a moderator. **Sample/Setting:** Data was taken from the National Longitudinal Study of Youth 1997 with a total sample of 3,646 females **Johns Hopkins Evidence Appraisal** **Level of Evidence:** II **Quality:** B	Interviews were conducted in 1997, with participants being re-interviewed in 2000, 2002, 2004, 2006, 2008, and 2010. Sixteen surveys that included "a short version of the Mental Health Inventory (MHI-5)…a reputable instrument to assess mental health" (p. 113).	First hypothesis: women that have suffered a miscarriage are likely to experience a decline in mental health status. The study also found that women who experienced both a live birth and a miscarriage were likely to suffer a decline in mental health. Second hypothesis: religious participation provider internal tools for coping by providing a social support network and a meaning to stressful situations in life. **Conclusion:** Religion could be an importance aspect of coping after the loss of a pregnancy.	**Strengths:** Strong findings as indicated with the three hypotheses. **Limitations:** The mental health inventory was only asked in some waves of the interviews. Religious indicators were limited to participation, not enough information about the actual participation process to conclude on the actual processes that aided

			coping mechanisms. The sample of women was relatively young.

Author Recommendations:
Future studies should include more religious measures to truly have a comprehensive assessment on miscarriage, religion, and mental health. A proposal was made to continue to interview the same sample of women to continue to assess the relationship between miscarriage, religion, and mental health to explore if age changes the findings.
Also, further studies should be done to explore the coping strategies and consequences in parents that suffer a miscarriage.

Implications:
Religion can help improve mental health outcomes for women that have suffered a miscarriage.

Source: CINAHL Complete
Keyes, C. L. & Reitzes, D. C. (2007). The role of religious identity in the mental health of older working and retired adults. *Aging & Mental Health*, *11*(4), 434–443.

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To verify if religious identity explains a difference in self-esteem and depression in older working and retired adults. **Sample/Setting:** 242 participants in a North Carolina metropolitan area. **Johns Hopkins Evidence Appraisal**	A survey consisting of religiosity measures and attendance. Rosenberg 10-item scale was used to measure self-esteem. Epidemiological Studies Depression Scale (CES-D) was used to measure depression symptoms.	High self-esteem and low depression symptoms were reported by the older adults positive religious identities; therefore, religious identity noteworthy predictor of mental health. • 33% of relationship between religion and depression were explained by self-esteem. • 31% of the relationship between religion and self esteem was explained by the level of depression.	**Strengths:** Findings that religious identity better predicts self-esteem and depression in retirees compared to older working adults **Limitations:** Because religious identity was added late in the data collection, causality or consequence cannot be confirmed in relation to mental health.

Level of Evidence: III **Quality:** B		**Conclusion:** Increased self-esteem and decreased depression symptoms correlated with the increase of religious identity.	
Author Recommendations: Future studies are needed on religious behaviour, religious identity, and mental health.			
Implications: Improved mental health could help individuals understand the dissemination of good and bad fortunes.			

Source: PsychINFO Jang, M., Ko, J.-A., & Kim, E. (2018). Religion and mental health among Nepal earthquake survivors in temporary tent villages. *Mental Health, Religion & Culture*, *21*(4), 329–335. https://doi-org.ezproxy.bethel.edu/10.1080/13674676.2018.1485136			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To survey if a relationship exists between mental health and religion through the frequency of prayer in earthquake survivors. **Sample/Setting:** 111 children in Nepal that survived an earthquake **Johns Hopkins Evidence Appraisal**	Religion: Two questions were asked – perceived importance of religion scored on a five-Likert scale, and if number of daily prayer increased. Mental health: higher scores on the Child Behavior Checklist 6-18 (Nepalese version) indicated an increase of internalization of problems. Patient Health Questionnaire-15 was used to analyze somatic symptoms.	Groups with a low daily prayer frequency correlated with high level of anxiety and depression, increased somatic symptoms, and internalization of symptoms. This could be because children are not as mature and they have a perceived association of frequent prayer with culture. **Conclusion:** The group that pray less exhibited increased mental health symptoms of anxiety and	**Strengths:** Discovery that contradicts past research – after an occurrence of a natural disaster, people do not necessarily become more dependent on religion. **Limitations:** Sample group was children only which comes with certain limitation: immaturity, perceived religious practices, lack of

Level of Evidence: III **Quality:** B		depression.	understanding of after life or how to change the impact.
Author Recommendations: Future studies should investigate the relationship between religion, culture, and mental health in the country's culture.			
Implications: None. More research is needed to expand the sample size to children and adolescents. Qualitative studies are needed to explore themes in attitudes and behaviour.			

Source: PyschINFO AbdAleati, N. S., Zaharim, N. M., & Mydin, Y. O. (2016). Religiousness and mental health: Systematic review study. *Journal of Religion and Health*, *55*(6), 1929–1937. https://doi-org.ezproxy.bethel.edu/10.1007/s10943-014-9896-1			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To review the literature on religion and mental health. **Sample/Setting:** Seventy-four articles from Social Sciences Citation Index, PsychInfo, and Proquest. **Johns Hopkins Evidence Appraisal** **Level of Evidence:**	The literature review found articles in English and Arabic using the following keywords: "religion and mental health, religiousness and depression, religiosity and religion anxiety, religion and substance abuse" (p. 1931).	Religious participation in a formal setting is associated with opposition results in mental health symptoms of anxiety and depression. Specific religious practices implied a decrease in suicide, substance abuse, anxiety, and depression.	**Strengths:** Findings indicated that religion can help individuals form goals and cope better with anxiety and depression. **Limitations:** None mentioned.

III **Quality:** B		**Conclusion:** Religion plays a major role because often the beliefs influence life choices and physical health care.	
Author Recommendations: None			
Implications: Religious practices could help improve mental health by providing some sort of therapy for controlling anxiety and depression, as well as managing substance abuse and reduce the rate of suicides.			

Source: CINAHL Complete Omenka, O. I., Watson, D. P., & Hendrie, H. C. (2020). Understanding the healthcare experiences and needs of African immigrants in the United States: A scoping review. *BMC Public Health*, *20*(1), 1–13. https://doi-org.ezproxy.bethel.edu/10.1186/s12889-019-8127-9			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To examine the present information on African immigrant health in the United States. **Sample/Setting:** Articles found on EBSCOhost, ProQuest, PubMed, and Google Scholar. A total of 14 articles were used for the review.	Inclusion criteria for the search included the following: • Years 1980-2016 • English language • Peer-reviewed articles • Non-refugee immigrants • Healthcare experiences and behaviour of immigrants • Data collected from participants (no	Traditional beliefs – multiple sources finding patterns of seeking care only when symptoms are advanced or interfering with daily function. In addition, traditional healers are consulted when illnesses are viewed as spiritual issues. Spirituality – the general belief that health outcomes are determined by God, despite physicians being able to provide treatment solutions.	**Strengths:** This is the first scoping review to examine the needs of immigrant Africans and their healthcare needs. **Limitations:** Only articles in English

Johns Hopkins Evidence Appraisal **Level of Evidence:** V **Quality:** A	secondary articles used). Arksey and O'Malley's Scoping Review framework was used to research a topic.	Stigma – the shame that certain diagnosis carry within the community that act as a barrier to seeking care. **Conclusion:** Knowledge of immigrant African health is limited.	were selected. Other articles in different languages could have yielded more results. Also, only peer-reviewed articles were used, excluding those in grey areas. Refugee population articles were also excluded from the search.
Author Recommendations: Future studies are needed to understand the cause of identified barriers			
Implications: Healthcare providers can better understand the needs of immigrant Africans and provide more cultural-centric care to improve health outcomes.			

Source: PsychINFO Bakibinga, P., Vinje, H. F., & Mittelmark, M. (2014). The role of religion in the work lives and coping strategies of Ugandan nurses. *Journal of Religion and Health*, *53*(5), 1342–1352. https://doi-org.ezproxy.bethel.edu/10.1007/s10943-013-9728-8			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To examine the role of religion in the work and coping strategies of nurses undergoing job stress. **Sample/Setting:** Fifteen actively religious female nurses from facilities that are	In-depth interviews conducted over 3 months between March and May of 2010.The interviews included background information, coping strategies of work stress, and self-care activities.	Four themes emerged from the interviews: • A calling to the profession to serve others. Some felt the calling was from God. • Shared experiences on the job with feeling value when serving and relating it to Christianity.	**Strengths:** Supports earlier studies: coping with stressful situations was aided by religion.

faith and non-faith based in Uganda. **Johns Hopkins Evidence Appraisal** **Level of Evidence:** III **Quality:** B		• Coping with job related stress through prayer and group activities. • Self-care to maintain holistic well-being. **Conclusion:** The study found that religion positively affected work and allowed nurses to find meaning even during difficult situations.	**Limitations:** The sample was limited to one gender. The interviews that were conducted in Luganda (local language used in Uganda) and translated into English may have lost some information during the translation process.
Author Recommendations: Future studies should include nurses that are not actively religious to investigate their coping strategies with work stress.			
Implications: This study's findings are an important step towards understanding how religion promotes success at work.			

Source: PsychoINFO Simmelink, J., Lightfoot, E., Dube, A., Blevins, J., & Lum, T. (2013). Understanding the health beliefs and practices of East African refugees. *American Journal of Health Behavior*, *37*(2), 155–161. https://doi-org.ezproxy.bethel.edu/10.5993/AJHB.37.2.2			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To understand the ideas and beliefs of healthcare of East African refugees. **Sample/Setting:** Fifteen East African community leaders and health	Two focused groups conducted in English each lasting 90 minutes. The interview had structure with probing questions on illness prevention, health promotion, coping with an illness, and community resources that are available.	The results were put into three categories: Illness prevention – religious prohibitions of smoking, drinking, illicit drug use, and certain sexual practices for some groups. Coping with illness – religious activities like prayer and reading that reduce anxiety and	**Strengths:** A key finding was that that treatment services were more likely to be accessed if another community member vouched for it.

professionals. **Johns Hopkins Evidence Appraisal** **Level of Evidence:** III **Quality:** B		manage stress, God determines health, prayer treats mental health illness, certain food and herbs treat illness. Sharing information – done in social settings, resources are more likely to be used if another community member vouches for them. **Conclusion:** East African refugees have strong traditional practices for coping with both physical and mental illness.	**Limitations:** There were limitations on size and scope due to the exploratory nature of the study
Author Recommendations: Due to the importance of vouching for health services, future research is needed to explore ways to adapt health education to be more culturally centric to this population.			
Implications: Health professionals can use the information to better understand and be aware of the health practices of East Africans to improve on health outcomes.			

Chapter 4: Discussion, Implications, Future Research

The aim of this critical review of literature was to investigate if a relationship exists between spirituality and mental health in Kenyans living in the United States. The article review was expanded to include four additional African countries. There were similar beliefs shared by the Africans; therefore, this chapter discusses the themes presented in the literature search, as well as inferences that are made to apply to the Kenyan population.

Discussion

The mental health stigma is a recurrent theme in Africans and mental health. It is the

leading barrier in seeking care. The case by Anglero (2018) pointed out that stigma played a large role and that children with mental health symptoms were treated different, which led to underreporting of symptoms. This often leads to shame and living with the secret of a mental illness without any resources on alleviating the problem. The study by Getanda et al. (2017) made similar conclusions and pointed out the fear of divulging any mental health symptoms to avoid potential bullying from peers. The fear of being viewed as different within the community often drives the need to live in secret. Individuals are less likely to discuss mental health symptoms among each other for support. The study by Omenka et al. (2020) described the stigma as a shame that is carried by the individual. The studies reinforced that stigma is associated with poor mental health outcomes. Addressing the negativity that stigma holds can be the first step in breaking down the barrier to individuals seeking care.

There is a general theme of a lack of resources for mental health care cited by multiple studies. Getanda et al. (2017) noted limited resources especially in developing countries with the government either not prioritizing funding for mental health, or not enough trained health professionals to address concerns. In addition, individuals in rural setting face more challenges when they have to consider transportation to a different city to see a mental health professional (Vergunst, 2018). The lack of resources presents another layer to the barriers that already exist in seeking mental health care.

Another recurrent theme in Africans is immigration. Lasebikan (2016) found that refugees had a higher rate of mental illness. This could be due to the unique stress factors of immigration, acculturation, and socioeconomic changes. On the other hand, Simmelink et al. (2013) found that refugees can cope with mental health illness due to strong traditional practices. This could be as a result of social support and being surrounded by a group undergoing the same

circumstances.

The results indicated that there is a link between spirituality and mental health as a central theme in Africans. There is a shared cultural belief on the etiology of mental illness. Anglero (2018) pointed out that the belief that mental illness was caused by evil spirits was shared by majority of Kenyans. Similarly, the study by Akol et al. (2018) pointed out the view of Ugandan traditional healers that mental health illness was caused by ancestral spirits that were unhappy or as a result of witchcraft due to jealousy towards individuals that are prosperous. These beliefs can contribute to a knowledge deficit on mental health and appropriate interventions (Getanda, 2017). Africans are more likely to seek treatment from a spiritualist or a traditional healer due to the belief that mental health is a spiritual punishment. African also believe that health outcomes are out of their control and determined by God (Omenka et al., 2020). The cultural beliefs and spiritual practices should be taken into consideration when planning interventions to facilitate better mental health outcomes in African patients.

Similarly to spirituality, the results also indicated a link between mental health and religion. While spirituality helped explain the source of mental health, religion indicates specific practices that help alleviate and cope with mental illness. Kovess-Masety et al. (2017) found that individuals facing mental health challenges found comfort in religion. This is because religion offers a social support network and a place of service for participants to attend. Petts (2018) found that religion helped cope with the loss of a pregnancy because participants were able to have access to a religious community. Specific practices such as prayer, meditation, and study provide coping mechanism that help participants process mental health challenges (Jang et al., 2018; AbdAleati et al., 2016; Bakibinga et al., 2014).

Implications for Nursing Practice

The critical review of the literature supports the assertion that a link exists between mental health and religion in an African population. When considering mental health interventions for Kenyans living in the United States, stigma, culture, and a lack of education on mental health disorders should be considered. It is important to normalize mental health disorders and start a discussion to break down the negativity of stigma. This process can start at the undergraduate level by preparing future nurses to provide care for patients with mental illness. According to Happell (2020), "the crisis in the mental health workforce will not improve, and likely deteriorate further, unless we attract sufficient number of nursing graduates into the field" (p.42). Discussing the negative stereotypes and attitudes toward mental health care can provide room for education and holistic care.

Application of Theoretical Framework

Leininger's transcultural theory offers a framework to provide culturally sensitive care to this population. Nurses need to start by developing awareness to the different cultural practices of their patients and integrate interventions that can improve health outcomes. The western model of using medication alone may not be enough for this group of individuals. Cultural assessments can evaluate gaps in knowledge to better educate patients on mental health disorders. The case by Anglero (2018) found that the patient's parent was open to education to better understand the relationship between stress and mental health. By addressing the factors that are unique to this cultural group, it is possible to provide the cultural care to meet the needs of the population. In addition, spirituality and religion can be used to provide coping mechanisms such as prayer and meditation. Research indicates that Africans are more likely to seek care from a spiritual leader. Perhaps providing resources and education to religious leaders will provide a gateway for this population to gain resources that can help address the challenges that mental

health disorders bring.

Future Research

Future research is needed on Africans in a religious group or denomination to explore their view on mental health disorders. A qualitative study is needed to explore the attitudes towards mental health disorders and seeking care to understand the themes the current critical review found. The study should be conducted in a focus group or individual interviews. Additional studies should include church leaders and their view on mental health. As research has indicated, church leaders are the front line of intervention when mental health challenges are faced in a cultural community; therefore, it is important to investigate their current views and knowledge base.

Conclusion

Patients from an African cultural background with mental health illness create a challenge for nurses. Stigma is a leading barrier for this population seeking care. The risk of ostracization for the community is a motivator to live in secret. In addition, Africans generally lack the knowledge and resources to identify and seek care for mental health issues. This group of patients do not gravitate towards western medication and interventions to tackle these disorders. Nurses need to have cultural sensitivity and competence when managing holistic care. Cultural and religious practices should be considered in implementing care.

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