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Review Article

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Utilization of mental health services among Black African immigrants in the US: Integrative literature review

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ABSTRACT

Background: Black African immigrants–individuals born in sub-Saharan Africa who now reside in the United States, irrespective of citizenship status–represent one of the nation's fastest-growing immigrant groups. Although they contend with migration stress, racism, cultural dislocation, and socioeconomic hardship, they remain among the least likely to seek or receive mental-health services. This persistent under-utilization, coupled with scant empirical attention, leaves their distinct needs largely invisible in mental-health research and policy.

Purpose: This integrative review examines multilevel factors influencing mental health service (MHS) utilization specifically among Black African immigrants in the United States, foregrounding structural, cultural, and psychosocial barriers.

Methods: Following integrative review methodology [1], 19 peer-reviewed studies published between 2000 and 2025 were analyzed using thematic synthesis and constant comparative analysis. A conceptual framework grounded in intersectionality, Stigma and race-related stressors, and structural competency guided the review.

Results: Five major themes emerged: (1) underutilization despite need, (2) structural barriers and systemic exclusion, (3) cultural and religious interpretations of mental illness, (4) stigma and silence within communities, and (5) the role of acculturation and identity. These themes highlight the complex interplay of stigma, systemic racism, and sociocultural dynamics influencing help-seeking behaviors.

Conclusion: MHS underutilization among Black African immigrants is shaped by interlocking individual, cultural, and structural barriers. Culturally and structurally responsive interventions are urgently needed to improve access and engagement. The review underscores the importance of population-specific research, disaggregated data, and community-partnered models of care.

Keywords: Black African immigrants, mental health services, stigma, structural barriers, intersectionality, help-seeking behavior, structural competency

INTRODUCTION

Mental health disparities remain a persistent and under-addressed issue within immigrant populations in the United States. Black African immigrants–people born in sub-Saharan Africa who now reside in the United States, regardless of citizenship status–represent a rapidly growing demographic that faces a distinctive constellation of barriers to accessing mental-health care. According to [2, 3], the African-born population in the United States has more than doubled in recent decades. Yet, this population remains largely understudied in public health research. Despite experiences of migration stress, racism, cultural dislocation, and socioeconomic hardship, Black African immigrants are among the least likely to utilize mental health services (MHS) in the United States [4]. These low utilization rates cannot be attributed solely to personal reluctance. Instead, they reflect deeper intersections of stigma, structural inequities, and the erasure of cultural specificity in dominant mental health frameworks [5, 6].

Mental health stigma in African immigrant communities is often compounded by cultural, spiritual, and communal understandings of mental illness that diverge from biomedical models [6]. Simultaneously, structural racism, linguistic barriers, lack of culturally competent providers, and fear of discrimination discourage engagement with mainstream services [5, 7]. These challenges are further shaped by social determinants of health such as housing, employment, insurance status, education, and immigration policies [7]. Yet much of the existing literature fails to account for the intersectional and racialized nature of these barriers, often grouping Black African immigrants with African Americans or treating immigrant experiences as monolithic. Scholars and community organizations have recently called for innovative, culturally responsive interventions that address these structural and cultural barriers, yet the literature remains scattered and understudied.

While studies such as [9, 10] have provided valuable insights into MHS utilization among African Americans and Caribbean Blacks, they do not include African immigrants. The foundational national survey of American life [11], which informed much of the subsequent research on racial disparities in mental health, also excluded African-born populations from its sampling framework. These studies, based on extensive national surveys, underscore the influence of racial discrimination and ethnic identity on help-seeking behaviors. However, the absence of African immigrants from such analyses limits our understanding of how migration histories, cultural belief systems, and structural exclusion uniquely affect mental health engagement in this group. This omission contributes to a broader pattern in which Black African immigrants are either grouped with African Americans or excluded altogether, despite significant contextual differences.

To address this gap, an integrative review is needed to synthesize the current state of evidence related to MHS utilization among Black African immigrants in the United States. Unlike systematic reviews that often prioritize methodological uniformity, integrative reviews accommodate a broad range of study types and designs, allowing for a more comprehensive understanding of complex phenomena across diverse contexts [1]. This methodological flexibility is especially useful in studying under-researched, heterogeneous populations such as Black African immigrants.

This review is especially timely given widening disparities amid ongoing social, economic, and political shifts. Research emphasizes that stigma is not merely an individual experience but an amalgam of intersecting social identities and systemic inequalities [12]. This review is therefore framed by three complementary frameworks: intersectionality and Stigma, race-related stressors and health, and structural competency. Together, they offer a multidimensional lens for examining how stigma, structural racism, and intersecting identities impact access, utilization, and engagement in MHS.

Purpose

This integrative literature review examines the factors influencing MHS utilization among Black African immigrants in the United States. The review synthesizes evidence related to access, barriers, stigma, social determinants, and culturally or structurally responsive interventions. This review applies intersectional, stigma-sensitive, and structural perspectives to highlight how social systems and individual identities influence mental health engagement. The goal is to guide more inclusive practices and policies.

Research Questions

1. What factors influence the utilization of MHS among Black African immigrants in the United States?
2. How do stigma and intersecting identities–such as race, immigration status, and cultural background–shape help-seeking behaviors and perceptions of mental health care in this population?
3. In what ways do race-related stressors and social determinants of health influence access to MHS Black African immigrants?
4. What structurally or culturally responsive interventions have been proposed or implemented to improve MHS utilization among Black African immigrants in the United States?

PROBLEM IDENTIFICATION

Although the population of African-born individuals in the United States has more than doubled over the past two decades, mental health research continues to treat the Black immigrant experience as monolithic or conflate it with African American populations [3]. This erasure obscures the specific sociocultural, structural, and psychological realities facing Black African immigrants, resulting in inadequate data and poorly tailored interventions.

Multiple intersecting barriers contribute to the underutilization of MHS in this population. These include cultural stigma, mistrust of Western mental health systems, immigration-related stressors, and unfamiliarity with available services [4, 7]. Many African cultural frameworks interpret mental distress through spiritual, moral, or communal lenses, which may conflict with biomedical models and discourage help-seeking [6]. Additional deterrents include fear of discrimination, language barriers, and concerns about immigration status.

These challenges are further shaped by broader social determinants of health, including economic insecurity, housing instability, limited health insurance, and educational disparities [8, 13]. For Black African immigrants, these determinants intersect with racialization, transnational identities, and settlement experiences [14]. Research also shows that limited English proficiency and unstable employment decrease the likelihood of engaging in preventive or psychiatric services [5, 7]. Yet most mental health outreach and care models remain designed for either the general population or African Americans, overlooking the distinct linguistic, cultural, and migration-related needs of African immigrants [15].

While some community-based and culturally grounded interventions have been successfully implemented in Latinx and African American communities [15], very few have been adapted specifically for African immigrant populations [2-4]. The lack of targeted programs results in fragmented care and limited engagement. A more nuanced understanding of how individual and structural forces shape access to care is urgently needed.

Integrative reviews are particularly suited for this type of inquiry. Incorporating diverse study types and perspectives allows for a comprehensive synthesis of empirical evidence and theoretical insights [1]. This approach enables a critical examination of how Black African immigrants experience and engage with mental health systems, where the literature falls short, and what kinds of equity-oriented interventions are most promising.

THEORETICAL FRAMEWORK

The challenges identified in the literature–ranging from structural racism and stigma to underutilization of culturally congruent care–necessitate a robust conceptual framework.. Accordingly, this review integrates three complementary frameworks–intersectionality and Stigma, race-related stressors and health, and structural competency–to illuminate the complex forces shaping Black African immigrants' mental-health service use and to guide interpretation of the findings.

Intersectionality and Stigma

Intersectional stigma refers to the overlapping systems of discrimination experienced by individuals who hold multiple stigmatized identities [12]. Black African immigrants–marked by race, immigrant status, and distinct cultural practices–face layered stigma that may stem from race, ethnicity, immigration status, gender, language, and socioeconomic position, with profound mental- and physical-health implications. For this population, stigma is not merely a personal attitude toward illness; it is embedded in cultural and religious meanings of distress and reinforced by racialized healthcare encounters and immigrant exclusion [12, 17, 18].

Researchers note that stigmatized identities rarely act in isolation; instead, they intersect to heighten vulnerability and complicated service use [12, 19]. Stigma therefore operates simultaneously at structural, interpersonal, and intrapersonal levels, amplified where racialization, xenophobia, and mental illness meet. This framework clarifies how cultural shame, institutional neglect, and internalized fear converge to deter help-seeking among Black African immigrants–providing a vital lens for interpreting persistent underutilization even as population-specific studies continue to emerge.

Race-Related Stressors and Health

The value of a disaggregated lens for racialized mental-health disparities is established in Black mental-health research. Although the national survey of American life [11] distinguished African American and Afro-Caribbean populations, it excluded African immigrants, perpetuating their invisibility in national data and underscoring the need for population-specific, intersectional analysis.

Race-related stressors offer a biopsychosocial model for how structural and interpersonal racism erode mental health [20-22]. The study in [21] shows that discrimination acts not only as an external stressor but as a cumulative, embodied experience that drives poor outcomes. Among immigrants, these pressures intensify through acculturative demands, xenophobia, and the tension between ethnic identity and imposed the United States racial categories [23, 24].

Chronic exposure to racism correlates with higher rates of depression, anxiety, and psychological distress–even in communities with strong social cohesion [14, 25, 26]. For Black African immigrants, such exposure is internalized through intricate negotiations of cultural identity and social survival, rendering racism a proximal, embodied threat to well-being rather than a distant structural force.

Structural Competency in Healthcare

Structural competency, introduced by [27], shifts attention from individual or cultural traits to the social, economic, and political structures that shape health. The framework outlines five skills: recognizing how structures mold clinical encounters; developing an extra-clinical language of structure; reframing "culture" in structural terms; envisioning structural interventions; and practicing structural humility.

Geospatial analysis by [28] shows that immigrant-dense neighborhoods have lower mental-health service utilization, linking provider shortages and underfunded clinics to place-based inequities. These dynamics are particularly relevant for Black African immigrants, who also contend with limited insurance, unstable housing, and restrictive immigration policies–barriers no amount of cultural-competence training can overcome without systemic change. Incorporating structural competency thus highlights the need for institutional accountability and structural transformation in mental-health care.

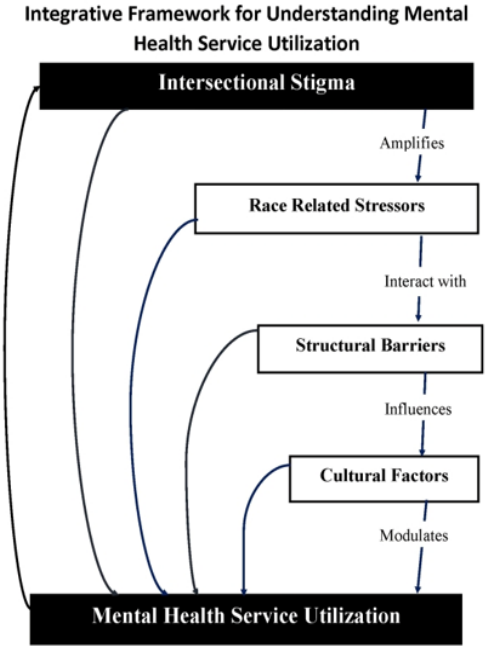

Figure 1. Integrative framework for understanding mental health service utilization (Source: Authors' own elaboration)

Integrative Conceptual Model

The literature reveals that the interplay between intersectional stigma, race-related stressors, and structural barriers creates a uniquely challenging environment for Black African immigrants. These frameworks are not mutually exclusive; instead, they intersect to shape lived experiences of care avoidance, underutilization, and systemic neglect. **Figure 1** provides an integrative conceptual model that visually synthesizes these dynamics. **Figure 1** illustrates how intersectional stigma, race-related stressors, structural barriers, and cultural factors interact to influence mental health service utilization among Black African Immigrants. The model synthesizes theoretical constructs to frame the review's subsequent analysis and discussion.

Application for the Review

This integrative review applies to the frameworks of intersectionality and Stigma, race-related stressors and health, and structural competency throughout the research process–from formulating research questions to data extraction, coding, and synthesis. These frameworks shape the thematic analysis by illuminating how stigma, structural racism, and intersecting identities influence help-seeking behaviors, service engagement, and intervention outcomes. Together, they support a holistic and equity-driven understanding of MHS underutilization among Black African immigrants and inform recommendations for culturally and structurally responsive practices.

METHOD

To explore the factors influencing MHS utilization among Black African immigrants in the United States, this study employed an integrative review methodology outlined by [1]. This approach was selected for its methodological flexibility, allowing the inclusion of diverse empirical and theoretical literature to provide a comprehensive understanding of complex health phenomena. Unlike systematic reviews that limit inclusion to studies with similar designs, the integrative review method accommodates qualitative, quantitative, mixed-methods, and review articles, thus enabling a more holistic synthesis of knowledge across disciplines.

The review was conducted in five stages:

(1) problem identification,

(2) literature search,

(3) data evaluation,

(4) data analysis, and

(5) presentation of findings.

Each stage was carried out systematically to ensure rigor, transparency, and relevance. The focus remained on peer-reviewed literature addressing Black African immigrants' MHS utilization within the United States context, with particular attention to barriers, facilitators, social determinants of health, and culturally responsive interventions.

Literature Search

A comprehensive literature search was conducted to identify peer-reviewed articles relevant to the utilization of MHS among Black African immigrants in the United States. Following [1] integrative review methodology, the search strategy was designed to include a broad range of empirical and theoretical literature that reflects the multifaceted nature of MHS access, social determinants of health, and intervention development for this population.

Databases and Search Strategy

The following electronic databases were searched: CINAHL, PsycINFO, Academic Search Complete (EBSCO), PubMed, and Web of Science. These databases were selected for their comprehensive nursing, public health, psychological, and interdisciplinary health research coverage. Searches were conducted using Boolean operators to combine keywords and phrases across three conceptual domains:

(1) population (Black African immigrants),

(2) MHS utilization, and

(3) barriers/facilitators/interventions.

A sample of key search strings included:

- "Black African immigrants" AND "mental health services"
- "sub-Saharan immigrants" AND "mental health utilization"
- "culturally tailored interventions" AND "African immigrants"
- "mental health access" AND "African immigrant" AND "United States"

Additional search techniques included backward citation tracking of key articles and manual searches of high-impact journals related to immigrant health, mental health disparities, and transcultural nursing.

Inclusion and Exclusion Criteria

Articles were selected based on the following inclusion criteria:

- Published between 2000 and 2025 to capture contemporary trends in migration, healthcare access, and mental health discourse.
- Explicitly focused on Black African immigrants residing in the United States.
- Written in English.
- Included original peer-reviewed research (qualitative, quantitative, or mixed methods) or literature reviews relevant to the research questions.
- Addressed at least one of the following themes: utilization of MHS, barriers/facilitators to access, social determinants of health, or culturally tailored interventions.

The exclusion criteria were as follows:

- Studies exclusively focused on African Americans or non-US immigrant populations.
- Articles that did not primarily focus on mental health or service utilization.
- Editorials, commentaries, dissertations, book chapters, or grey literature.
- Duplicate studies or those lacking methodological clarity.

Screening and Selection Process

A comprehensive literature search was conducted across five electronic databases: CINAHL, PsycINFO, EBSCO, PubMed, and Web of Science, yielding 11,977 records. All retrieved citations were imported into Zotero, a citation management tool, and screened in two phases: an initial title and abstract review followed by full-text assessment. After removing duplicates and irrelevant titles, 159 articles were retained for screening.

Two reviewers independently assessed each record for eligibility. Discrepancies were resolved through discussion or, when necessary, consultation with a third reviewer to reduce the potential for selection bias. **Table 1** shows a summary of the literature search. Studies were excluded if they did not

Table 1. Literature search summary

Database	Records found	Screened after removing duplicates and irrelevant titles	Retained for abstract and rapid full-text review	Included in full-text detailed review	Included in final review
CINAHL	8	6			
PsycINFO	12	11	52	38	19
EBSCO	7,558	76			
PubMed	4,387	59			
Web of Science	12	7			
Total	11,977	159			

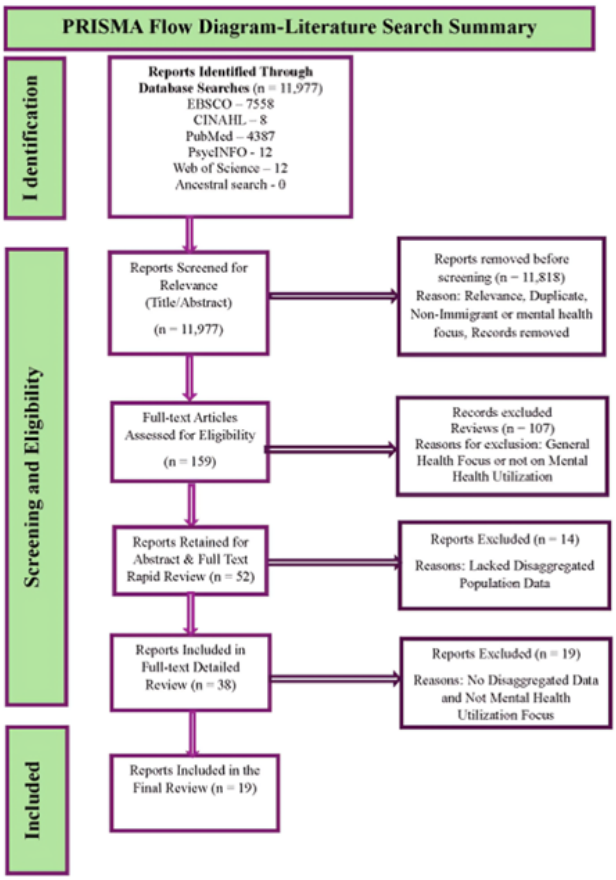

Figure 2. PRISMA flow diagram–Literature search summary (Source: Authors' own elaboration)

meet the inclusion criteria. A total of 52 studies were retained for rapid full-text review. Of these, 38 underwent detailed full-text analysis, and 19 met all inclusion criteria and were incorporated into the final synthesis. **Figure 2** shows a PRISMA 2020 flow diagram that will illustrate the study identification, screening, exclusion, and inclusion process [29].

Quality Appraisal

To ensure methodological rigor, all studies that met the inclusion criteria were appraised using the mixed methods appraisal tool (MMAT), version 2018, consistent with [1] integrative review guidelines. Using a unified five-criteria framework, MMAT was selected for its ability to assess the quality of diverse empirical designs, including qualitative, quantitative, and mixed-methods research.

Each study was independently assessed by two reviewers, evaluating:

- Appropriateness of the study aim and design
- Sampling strategy and relevance
- Data collection and measurement quality
- Control for bias and confounders
- Clarity and coherence of findings

Discrepancies in appraisal were resolved through discussion or adjudication by a third reviewer. While no studies were excluded based solely on MMAT scores, quality ratings were used to guide the interpretation and weighting of evidence during synthesis. Appraisal summaries are presented alongside extracted data in the review matrix (see **Table 2**).

Table 2. Data extraction table

Author (year)	Study design	Sample & setting	Focus area	Key findings	Social determinants addressed	Culturally tailored elements	MMAT score or notes
Ayele et al. (2020)	Cross-sectional survey	297 Ethiopian immigrants and refugees in the United States	Factors influencing MHS utilization	Only 13.3% used MHS from professionals; gender, marital status, and employment predicted MHS use	Perceived discrimination, income, education, employment, language proficiency	Adapted survey tools; culturally relevant measures (e.g., BRFSS and MSPSS)	Used Andersen's model + added post-migration discrimination
Boundaoni (2015)	Mixed methods	African immigrants in DC-Maryland area	Health care access and utilization	Low access and satisfaction; acculturation level influenced service use	Immigration status, acculturation, education, insurance, income	Survey distributed in churches, mosques, social events	Used Andersen's model; SPSS analytics
Deng and Rose (2025)	Cross-sectional survey	202 racial/ethnic minority immigrants	Stigma and help-seeking	Stigma increased informal help; reduced formal help-seeking	Race, insurance, religiosity, time in the United States.	Included traditional help-seeking paths	CDHS-based; validated model
Derr (2016)	Systematic review	62 US-based studies	MHS use patterns and barriers	Lower service use among immigrants; structural and cultural barriers	Insurance, cost, language, documentation	Partnerships between informal/formal care	No MMAT; rigorous synthesis
Edem-Enang (2023)	Narrative inquiry	African immigrants in the United States	Conceptualization of mental illness and service use	Conflict between Western and African views; stigma, spirituality shaped help-seeking	Stigma, religious influences, cultural beliefs	Use of oral histories, spiritual framing	Narrative design; rich qualitative data
Galvan et al. (2022)	Narrative review	Literature review	Attitudinal barriers to MHS	Religious/spiritual and non-Western beliefs impact service use	Acculturation, religiosity, mistrust	Group-specific attitudes outlined	Synthesis of attitudinal barriers
Hall-Clifford et al. (2024)	Mixed methods	57 Ethiopians in Atlanta, GA	Community mental health and barriers	Stress seen as more acceptable to discuss than illness; pastors key	Religion, race, discrimination	Bilingual tools; CAB recruitment	CBPR; community engagement
Ho et al. 2013)	Conceptual review	Synthesized US studies	Mental health and barriers to service	Identified seven key barriers incl. mistrust, stigma, cultural mismatch	Racism, poverty, legal status	Proposed traditional healer inclusion	Non-empirical chapter

Table 2 (Continued). Data extraction table

Author (year)	Study design	Sample & setting	Focus area	Key findings	Social determinants addressed	Culturally tailored elements	MMAT score or notes
Myers et al. (2025)	Qualitative interviews	16 African immigrant pastors, TX	Pastors' role in mental health referrals	Spiritual-medical treatment integration; pastors as gatekeepers	Religion, immigration stress	Used vignettes; faith-language integration	Grounded theory
Niam (2013)	Qualitative interviews	8 West Africans in SF Bay Area	MHS-seeking experiences	Coping via spirituality, identity, collectivism	Financial strain, language, immigration stress	West African worldview emphasized	Dissertation; Afrocentric lens
Orjiako and So (2014)	Secondary data analysis	669 African immigrants (NIS)	Acculturation stress and MHS use	English proficiency and education predicted help-seeking	Education, family support, language	Berry's acculturation theory	National sample; regression analysis
Pederson et al. (2022)	Qualitative focus groups	22 Black immigrant women, IL	Stigma and mental health	Five themes incl. spiritual stigma, acculturative stress	Race, acculturation, religion	Community org recruitment; 'mind health'	High rigor; K > 0.80
Pederson et al., 2023	Cross-sectional survey	262 Black adults in the United States	MH knowledge and utilization	Specific knowledge predicted help-seeking	Education, ethnicity, citizenship	Ethnic group comparison	Alpha for GK score = 0.42
Pederson et al. (2022)	Cross-sectional survey	248 Black adults in the United States	Ethnic identity and stigma	Centrality increased intended stigma; lowered past stigma	Age, education, ethnicity	MIBI and RIBS use	Calls for longitudinal study
Saasa et al. (2021)	Cross-sectional survey	323 African immigrants	MHS utilization, barriers	Older age, religiosity, and education predicted use	Income, insurance, religiosity	Partnering with faith leaders	Used Andersen model
Tanwani (2023)	Qualitative descriptive	8 SSA immigrants, Baltimore	MHS experiences	Five barriers incl. fear, stigma, income, language	Language, insurance, immigration status	Thematic analysis; direct quotes	Small N; rich contextual insights
Tekeste (2022)	Cross-sectional survey	248 Ethiopian immigrants in the United States	Stigma, trust, and help-seeking	Mistrust reduced intentions; stigma NS	Language, religion, prior service use	Survey in Amharic and English	PhD dissertation
Venters et al. (2011)	Descriptive screening	87 Liberians in Staten Island	Community MH needs	MH one of top concerns; few referrals made	Insurance, trauma, poverty	CBO-led screening	Brief communication
Yusuf et al. (2022)	Cross-sectional survey	260 African immigrants, the United States	COVID-19 and mental health	15% new MH disorder; religiosity not protective	Income, marital status, discrimination	Faith org recruitment; DUREL scale	Pandemic-specific insights

Data Extraction

A standardized data extraction matrix was developed to systematically compile relevant information from each study that met the inclusion criteria. Unlike the screening and appraisal processes, which determined eligibility and methodological quality, this phase focused on capturing the substantive content needed for synthesis. For each study, the following elements were extracted:

- Author(s) and year
- Study design
- Sample characteristics and setting
- Focus area related to MHS utilization
- Key findings
- Social determinants of health are addressed
- Culturally tailored elements or contextual insights
- MMAT score or relevant quality notes

Two reviewers compiled and cross-verified the data to ensure accuracy and completeness. This structured matrix supported transparent comparison across studies and was the foundation for the following thematic synthesis.

DATA ANALYSIS AND SYNTHESIS

Following the integrative review methodology outlined by [1], data from the included studies were analyzed using an inductive thematic synthesis approach. The aim was to identify patterns and recurrent concepts across diverse methodologies and study populations related to MHS utilization among Black African immigrants in the United States.

Each study was first subjected to structured data extraction, capturing study characteristics, populations, outcomes, and culturally specific elements. The extracted data were then reviewed iteratively to identify converging and diverging findings. Through constant comparison, initial codes were developed and grouped into higher-order thematic categories reflecting shared barriers, facilitators, and sociocultural dynamics.

These emergent themes were explicitly mapped onto three guiding conceptual frameworks to enhance interpretive depth: intersectionality, Stigma and race-related stressors and health, and structural competency. This allowed the findings to be interpreted at the descriptive level and in relation to power, identity, and system-level forces shaping mental health care access and experiences in this population.

The themes were refined collaboratively, ensuring conceptual clarity and distinctiveness, and ultimately organized into five major categories:

(1) Underutilization despite need,

(2) Structural barriers and systemic exclusion,

(3) Cultural and religious interpretations of mental illness,

(4) Stigma and silence within communities, and

(5) Role of acculturation and identity.

These thematic domains are presented in the next section and discussed in relation to the reviewed literature and theoretical models.

Table 3. Inductively derived themes from included studies (theme overview)

Theme	Brief Description	Representative Studies
1. Underutilization despite need	Low use of professional mental health services despite reported emotional distress and diagnosable conditions	Ayele et al. (2020), Saasa et al. (2021), Derr (2016), and Ho et al. (2013)
2. Structural barriers and systemic exclusion	Legal, financial, linguistic, and policy-related constraints limiting access to care	Venters et al. (2011), Ho et al. (2013), Orjiako and So (2014), and Tanwani (2023)
3. Cultural and religious interpretations	Framing mental illness as spiritual imbalance or social disharmony; preference for informal care networks	Myers et al. (2025), Hall-Clifford et al. (2024), and Edem-Enang (2023)
4. Stigma and silence within communities	Anticipated shame and fear of judgment driving secrecy and avoidance of mental health care	Pederson et al. (2022), Tekeste (2022), and Deng and Rose (2025)
5. Role of acculturation and identity	Language skills, ethnic identity, and education shaping help-seeking behavior and stigma	Orjiako and So (2014); Boundaoni (2015), and Pederson et al. (2023)

Table 4. Thematic mapping to conceptual frameworks

Theme	Intersectionality	Stigma & race-related stressors	Structural competency
1. Underutilization despite need	Reveals compounded marginalization due to overlapping identities (e.g., Black, immigrant, low-income)	Anticipated discrimination and community stigma inhibit help-seeking	Illustrates systemic failure to recognize and respond to immigrant mental health needs
2. Structural barriers	Legal status, race, and class converge to restrict access	Discriminatory systems produce psychological harm and treatment delays	Emphasizes how institutional policies and access structures shape health inequities
3. Cultural/religious interpretations	Cultural identity influences explanatory models and care-seeking paths	Stigma emerges through religious interpretations; illness may be spiritualized	Calls for integration of informal healers and faith leaders into culturally responsive systems
4. Stigma and silence	Gendered and racialized norms (e.g., emotional strength, shame) influence silence and suffering	Internalized stigma and anticipated social sanction suppress disclosure	Necessitates culturally contextualized anti-stigma interventions
5. Acculturation and identity	Ethnic identity, language, and migration stress intersect with racial positioning	Acculturative stress heightens vulnerability to mental distress and avoidance	Highlights need for linguistically and culturally adaptive mental health services

These themes are presented in the results section alongside two visual tables:

- **Table 3** outlines the five themes inductively derived from the dataset (step 1).
- **Table 4** maps each theme to the conceptual frameworks, highlighting their theoretical contributions (step 2).

This layered approach ensured conceptual richness and methodological transparency in understanding how African immigrants navigate mental health care in the United States.

Following the inductive thematic synthesis and mapping process described in the methods, five overarching themes emerged from the analysis of the 19 included studies. These themes reflect the individual, cultural, and structural dimensions that shape how Black African immigrants in the United States experience and engage with MHS. Each theme is presented below, accompanied by illustrative citations and interpreted through the guiding theoretical frameworks of intersectionality, Stigma and race-related stressors and health, and structural competency.

FINDINGS

All 19 studies included in this review examine Black African immigrants only; no data from US-born Black Americans or Afro-Caribbean immigrants were analyzed. Where a study presented mixed-immigrant samples, we extracted findings exclusively from the African-immigrant subgroup. The following five themes were inductively derived from the included studies and interpreted through the lens of intersectionality, Stigma and race-related stressors and health, and structural competency. Each theme is supported by multiple sources and reflects the complex, multi-layered barriers and experiences shaping MHS utilization among Black African immigrants in the United States.

Underutilization Despite Need

Despite high levels of emotional distress, depression, and trauma among African immigrants, a consistent finding across studies is their significant underutilization of professional MHS [17, 26, 30, 31]. This disconnect reflects both individual-level reluctance and system-level barriers. From an intersectionality perspective, overlapping identities–Black, African, immigrant, low-income–compound marginalization within mental health systems, making utilization less likely even when symptoms are present. This underutilization also reflects the structural invisibility of African immigrant needs within dominant models of care. It is further compounded by race-related stressors, such as anticipated discrimination, that discourage formal help-seeking despite demonstrated need.

Structural Barriers and Systemic Exclusion

For Black African immigrants, barriers including cost, legal status, lack of insurance, limited provider diversity, and language inaccessibility were reported across numerous studies [31-34]. These findings highlight the structural determinants of mental health and clearly align with the principles of structural competency, which calls for understanding how policies and institutional frameworks–not just individual behaviors–shape mental health outcomes. For Black African immigrants, these barriers are often intensified by racialized immigration laws and exclusionary health policies. Intersectionality underscores how the convergence of race, nativity, and socioeconomic status systematically denies access to care, while race-related stressors such as surveillance and deportation anxiety exacerbate psychological burden.

Cultural and Religious Interpretations of Mental Illness

A culturally salient pattern across studies was the framing of mental illness through spiritual, religious, or traditional lenses [35-37]. Many African immigrants turned to pastors, traditional healers, or family networks before considering Western providers, viewing mental distress as the result of spiritual imbalance or social disharmony. These findings reflect a critical need for structural competency, particularly the inclusion of culturally embedded healing practices into mainstream mental health care. At the same time, intersectionality reveals how these religious and cultural identities shape help-seeking behavior, while stigma theory illustrates how spiritual explanations can both normalize and stigmatize mental distress, depending on communal interpretations.

Stigma and Silence Within Communities

Stigma–both perceived and internalized–emerged as a powerful deterrent to MHS utilization [38-40]. For many, the fear of being labeled "mad" or bringing shame to one's family led to silence and avoidance. This theme reflects the role of race-related stressors–particularly the stigma amplified by both cultural norms and external racism. Intersectionality is critical in understanding how gender, especially for Black immigrant women, intersects with cultural expectations of emotional endurance, reinforcing silence [39]. Structural competency demands a shift in public health messaging and provider training to address stigma not only as an individual belief but as a product of social, cultural, and institutional forces.

Role of Acculturation and Identity

Studies examining English proficiency, ethnic identity, and cultural adaptation [32, 41, 42] show that these factors significantly influence both mental health outcomes and service engagement. While higher acculturation (e.g., language proficiency) predicted greater service use, ethnic identity centrality sometimes increased stigma or moderated help-seeking. These findings illustrate how intersectionality plays out dynamically–where education and assimilation may confer benefits in one context and reinforce stigmatization in another. Stigma and race-related stress emerge through the lens of acculturative stress, and structural competency is required to recognize how health systems must adapt to these identity tensions rather than forcing immigrants to fit dominant norms.

DISCUSSION

This integrative review reveals that Black African immigrants in the United States face complex, multi-level barriers to MHS utilization–barriers that span individual, cultural, and structural domains. While some findings may superficially support the healthy immigrant effect [43], the consistently low rates of diagnosed psychiatric disorders and formal help-seeking likely reflect underdiagnosis, stigma, and systemic exclusion rather than the absence of need. The five emergent themes–underutilization despite need, structural barriers, cultural/religious interpretations, stigma and silence, and acculturation and identity–underscore the importance of analyzing help-seeking through the lenses of intersectionality, Stigma and race-related stress, and structural competency.

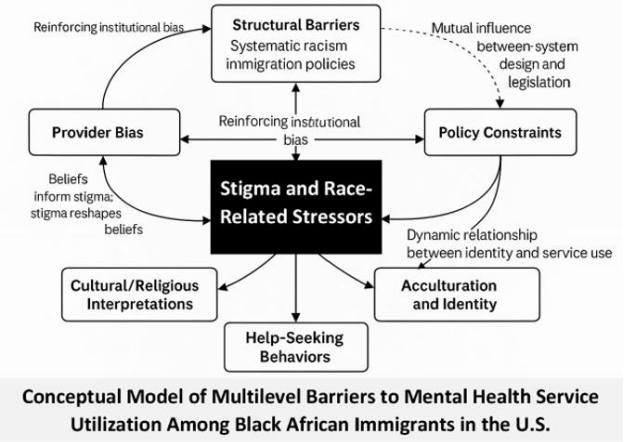

Figure 3. Conceptual model of multilevel barriers to mental health service utilization among Black African immigrants in the United States (Source: Authors' own elaboration)

To visually synthesize the thematic findings of this review, **Figure 3** presents a conceptual model illustrating how stigma, race-related stressors, structural barriers, and sociocultural factors interact–and often reinforce one another–to shape MHS utilization among Black African immigrants. The model places Stigma and race-related stressors at the center to reflect its mediating role across multiple domains. Bidirectional arrows highlight the reciprocal nature of these relationships; for example, provider bias both shapes and is shaped by structural conditions and community-level stigma. **Figure 3** integrates key insights from the review and is grounded in the guiding frameworks of intersectionality, structural competency, and Stigma theory.

Figure 3 synthesizes key findings from the integrative review, illustrating how intersectional stigma, race-related stressors, structural barriers, and sociocultural factors interact to shape help-seeking behaviors and service engagement. "Stigma and race-related stressors" is positioned centrally to reflect its role as both an outcome of and contributor to structural and interpersonal inequities. Bidirectional arrows highlight how these elements mutually reinforce one another–for example, how provider bias and structural barriers shape and perpetuate one another. The model synthesizes thematic findings from the integrative review and is grounded in the frameworks of intersectionality, race-related stressors, and structural competency. It underscores that mental health underutilization in this population is not a result of isolated factors but rather a product of interlocking and self-reinforcing social, cultural, and institutional forces.

Reflexivity and Use of Power in Conceptual Framing

The decision to place Stigma and race-related stressors at the center of the conceptual model reflects an intentional acknowledgment of how power operates within systems of mental health access and knowledge production. Rather than framing underutilization as a product of cultural reluctance or individual deficit, this model highlights how structural racism, provider bias, and policy exclusion actively produce and reinforce stigma within immigrant communities. Bidirectional arrows underscore the recursive nature of these dynamics–demonstrating that power flows in multiple directions across institutions, communities, and identities. This framing affirms the need to move beyond descriptive analysis toward a structural critique that centers historically marginalized

populations. In doing so, it reclaims conceptual space for African immigrant experiences and promotes epistemic justice within public health discourse.

Systemic Invisibility and Conceptual Gaps in the Literature

This review affirms that African immigrants have long been overlooked in the United States mental health disparities research. While earlier studies, such as [44], documented healthcare access disparities among immigrants, they failed to differentiate between service types (e.g., physical vs. mental health) or population subgroups. More recently, the study in [45] identified significant gaps in subgroup-specific analyses across US immigrant help-seeking studies, underscoring the urgency for population-specific reviews that center the racial, cultural, and structural forces uniquely impacting Black African immigrants. Compared with Caribbean Blacks and US-born Black Americans–groups whose help-seeking trajectories are increasingly documented–Black African immigrants remain virtually invisible in national behavioral-health datasets. Black African immigrants are often collapsed under generic racial categories or excluded altogether, in broad immigrant mental health syntheses compounding their erasure.

The study in [46] found that Black immigrants' health behaviors are shaped by the racialized environment in the United States, reinforcing the notion that systemic racism influences not only physical health decisions but likely extends to mental health help-seeking behaviors. This aligns with [47], which argues that public health frameworks frequently fail to explicitly name structural racism as a driver of immigrant mental health disparities–an omission that this review directly addresses through the application of structural competency as an analytic lens.

Cultural and Psychological Barriers to Mental Health Utilization

Cultural frameworks and social stigma powerfully shape perceptions of mental illness and help-seeking behavior among African immigrants. The study in [48] illustrated how internalized fear of community judgment and cultural constructions of strength can deter West African immigrants from accessing care. Similarly, the study in [49] found that perceived need and mental health literacy were key drivers of engagement across Black subgroups, reinforcing the importance of culturally embedded beliefs in shaping utilization.

The study in [15], in a typology developed from interviews with African immigrants in Montreal, identified several culturally rooted reasons for non-engagement: spiritual interpretations of distress, beliefs in self-reliance, fear of stigma, and reliance on informal care. Although their study was Canadian, the thematic parallels with US-based research are striking. These patterns demonstrate how cultural meaning-making processes–often moral or spiritual–can either facilitate or hinder pathways to care, depending on how well services acknowledge and respond to them.

Cultural Framing and Implications for Intervention Design

Findings from this review confirm that mental illness among African immigrants is frequently understood through communal, spiritual, or moral frameworks, rather than biomedical ones [6, 15, 50]. Participants across multiple studies framed distress as a social or spiritual imbalance, seeking support from religious leaders or cultural communities before pursuing professional help. These patterns underscore the need for culturally grounded interventions that do not merely translate Western models into different languages, but instead embed services within trusted institutions–churches, ethnic associations, and spiritual centers–that already serve as health intermediaries.

Culturally responsive models should be co-designed with community stakeholders to reflect the values, explanatory models, and priorities of those they aim to serve. Such models should also respect cultural understandings of distress and healing, while bridging those perspectives with accessible, non-stigmatizing clinical support.

Faith Institutions and Crisis-Responsive Mental Health Systems

Religious institutions emerged throughout this review as trusted sources of culturally congruent support and potential partners in mental health promotion. For example, the study in [37] found that African immigrant pastors were key intermediaries in identifying and managing serious mental health conditions–especially among younger congregants experiencing psychosis. These findings reinforce calls to integrate faith-based leaders into mental health outreach strategies not as peripheral stakeholders but as essential co-designers of culturally grounded care models.

The study in [51], while not disaggregating African immigrants, similarly observed a strong preference among persons of African ancestry for indigenous and non-Western healing practices–highlighting a broader mistrust of biomedical approaches that may also shape immigrant populations' engagement with mainstream mental health systems. These patterns affirm the critical role of spiritual leaders and informal support networks in shaping both perception and access.

The COVID-19 pandemic further revealed how fragile and exclusionary mainstream care systems can be for African immigrants. It was reported elevated psychological distress during the pandemic, compounded by language barriers, cultural mismatch, and the absence of crisis-ready support systems rooted in the community [].52 These findings underscore the urgency for mental health systems to build sustainable, culturally embedded, and crisis-responsive partnerships with the institutions already serving as de facto mental health providers.

Recognizing Internal Diversity and the Need for Disaggregated Research

A critical insight emerging from this review–and echoed in related international studies–is the internal diversity within the Black African immigrant population. As [15] demonstrate, factors such as education level, religion, gender, and country of origin significantly mediate how individuals interpret mental illness and navigate the mental health system. For example, participants with higher education levels were more likely to express concern over provider cultural competence, while others emphasized stigma, prayer, or moral failing as barriers. This variation demands that health systems abandon one-size-fits-all outreach strategies and instead implement tailored messaging and service design that reflect subcultural differences within African immigrant communities.

The frequent aggregation of African immigrants under broad racial or ethnic categories further obscures these meaningful variations in experiences, beliefs, and structural

vulnerabilities. The study in [10], for example, found that perceived discrimination was negatively associated with MHS use among Caribbean Blacks–highlighting the impact of racialized stressors–but African immigrants were notably absent from the dataset. This omission exemplifies the broader erasure of Black African immigrants from US mental health research. Given their unique migration histories, explanatory models, and social positioning, the experiences of African immigrants cannot be conflated with those of African Americans or Caribbean migrants.

This review reinforces the urgent need for disaggregated, population-specific research that centers the distinct voices, needs, and identities within the Black African immigrant population. Such research is essential for developing responsive, equitable mental health care that acknowledges both the shared and divergent challenges facing subgroups within this diverse community.

Implications for Structural Competency in Practice

Findings from this review–and supported by international evidence–underscore the limits of insurance coverage as a proxy for access. The study in [15], examining African immigrants in Canada's publicly funded healthcare system, found that barriers such as long wait times, poor provider communication, and culturally incongruent care continued to deter MHS utilization. This reinforces the premise of structural competency: that access is shaped not just by individual behavior or eligibility, but by larger institutional and systemic forces. Even in universal healthcare models, structural racism, implicit bias, and the underfunding of culturally competent services can limit engagement and perpetuate inequity [27]. These findings are especially relevant in the United States, where fragmented delivery systems and immigration-related exclusions compound coverage disparities.

Even when immigrant communities are geographically concentrated, they do not always benefit from increased service access. As the study in [28] observed, areas with higher immigrant density were associated with persistently lower rates of MHS use, suggesting that proximity alone does not overcome structural exclusion.

Bridging Theory to Action: Structural Solutions

Translating structural competency into practice requires more than cultural awareness training or surface-level diversity initiatives. Health systems must actively redesign MHS to account for the structural and cultural barriers that disproportionately affect Black African immigrants. This includes funding for community-based care models, integration of MHS into trusted institutions (e.g., churches, ethnic associations), and the development of provider training that critically addresses racism, immigration stress, and diasporic identity. Policies must also acknowledge the "invisible exclusions" within access, such as language discordance, provider turnover, and bureaucratic delays, that undermine engagement even when coverage exists. Drawing on [15] and US-based findings, the review supports the call for system-level interventions that confront not only who is served, but how, where, and under what assumptions care is delivered.

Policy and Practice Implications

Structurally competent care demands a shift from individual responsibility to institutional accountability. Two priority areas emerge from this review.

Policy level. At the federal level, data-collection instruments (e.g., NHIS and NSDUH) should adopt country-of-birth variables to permit routine disaggregation of Black immigrant subgroups, thereby informing targeted resource allocation. State Medicaid waivers can pilot culturally anchored integrated-care models co-located in trusted faith institutions serving African immigrant enclaves.

- Tailor funding rules so states can reimburse community-based services delivered in churches, mosques, and ethnic centers.
- Require equity impact assessments for any mental-health legislation affecting immigrant communities.

Practice level. Health systems should formalize partnerships with African diaspora faith leaders through compensated advisory boards and co-developed referral pathways. Embedding lay health workers ("cultural brokers") from Ethiopian, Nigerian, or Somali communities within outpatient psychiatry clinics has demonstrated improved appointment adherence and trust. Structural competency training for clinicians must therefore move beyond cultural-awareness workshops to include joint workflow redesign with these brokers.

- Co-design culturally grounded models of care with community stakeholders to ensure alignment with spiritual and explanatory frameworks.
- Tailor interventions for within-group diversity–education level, country of origin, religious belief–as these factors shape how mental health is understood and accessed among Black African immigrants [15].
- Prioritize population-specific, disaggregated research to avoid conflating African immigrants with African American or Caribbean experiences and to capture heterogeneous needs and barriers.

RESEARCH IMPLICATIONS AND GAPS

This review highlights several critical gaps in the literature on MHS utilization among Black African immigrants in the United States. Despite a growing African-born population, most empirical studies fail to differentiate between African immigrants, African Americans, and Caribbean Blacks. This lack of disaggregation obscures the cultural, structural, and migration-specific factors that influence help-seeking behaviors in these distinct groups. While studies such as [9, 10] offer valuable insights into mental health utilization among African Americans and Caribbean Blacks, they do not account for the unique sociocultural contexts of Black African immigrants. Although landmark studies like the national survey of American life [11] advanced our understanding of intra-racial mental health disparities, the persistent omission of Black African immigrants from national data sources reinforces the invisibility of this population's mental health needs. These studies illustrate a broader issue: excluding African-born individuals from national datasets and mental health surveys. This omission limits the generalizability of findings and perpetuates the design of policies and

interventions that fail to meet the needs of African immigrants, who face distinct barriers related to language, immigration status, and cultural frameworks of distress.

Moreover, this review reinforces the importance of incorporating intersectionality, stigma theory, and structural competency in mental health research design and interpretation. Studies that fail to consider overlapping axes of identity, such as immigration status, language, and religious affiliation, risk missing how these intersecting factors shape access to and perceptions of mental health care. Intersectional approaches also call attention to within-group variation. As shown in [15], variables such as education level, religion, and country of origin affect how barriers are perceived and navigated, further challenging the adequacy of one-size-fits-all research designs.

Finally, structural forces–including immigration policy, service delivery models, and racialized provider-client interactions–remain underexplored in much of the existing literature. Although structural competency provides a promising framework, few empirical studies directly assess how structural interventions (e.g., policy changes, institutional redesign, workforce training) impact mental health access or outcomes for this population. Future research must prioritize multilevel, equity-oriented methodologies that appeal to individual experiences and the broader systems in which care is delivered. Future research should explore how spatial segregation and resource distribution shape access for specific immigrant subpopulations. The findings of [28] suggest that place-based interventions must consider geographic concentration and cultural fit.

CONCLUSION

This integrative review sheds light on the persistent invisibility of Black African immigrants in US mental health systems and research. Despite growing population numbers and well-documented stressors related to immigration, racialization, and cultural transition, this population remains understudied and underserved. Findings reveal that barriers to MHS utilization are not merely individual or cultural but are deeply embedded in structural inequities, including exclusionary policies, institutional mistrust, and culturally incongruent care models.

By applying the lenses of intersectionality, Stigma and race-related stressors, and structural competency, this review highlights how overlapping identities, racialized environments, and system-level failures coalesce to produce underutilization. The diversity within the Black African immigrant population–by religion, education, migration history, and language–further complicates one-size-fits-all approaches to intervention and demands a more nuanced, equity-focused response.

To advance health equity, mental health systems must move beyond symbolic inclusion and invest in structurally competent, culturally grounded, and community-partnered models of care. Research, policy, and practice must center they lived realities of African immigrants, not as a footnote within broader immigrant or Black populations, but as a distinct group whose mental health needs reflect the unique intersections of race, migration, and structural marginalization in the United States.

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REFERENCES

1. Whittemore R, Knafl K. The integrative review: Updated methodology. J Adv Nurs. 2005;52(5):546-53. https://doi.org/10.1111/j.1365-2648.2005.03621.x PMid: 16268861
2. Anderson M, Lopez G. Key facts about black immigrants in the U.S. Pew Research Center; 2018. Available at: https://www.pewresearch.org/fact-tank/2018/01/24/key-facts-about-black-immigrants-in-the-u-s/ (Accessed: 25 May 2025).
3. Tamir C. Key findings about Black immigrants in the U.S.. Pew Research Center; 2022. Available at: https://www.pewresearch.org/short-reads/2022/01/27/key-findings-about-black-immigrants-in-the-u-s/ (Accessed: 25 May 2025).
4. Venters H, Gany F. African immigrant health. J Immigrant Minority Health. 2011;13(2):333-44. https://doi.org/10.1007/s10903-009-9243-x PMid:19347581
5. Botchway-Commey EN, Adonteng-Kissi O, Meribe N, et al. Mental health and mental health help-seeking behaviors among first-generation voluntary African migrants: A systematic review. PLoS One. 2024;19(3):e0298634. https://doi.org/10.1371/journal.pone.0298634 PMid: 38498578 PMCid:PMC10947684
6. Pierre MR, Mahalik JR. Examining African self-consciousness and Black racial identity as predictors of Black men's psychological well-being. Cultur Divers Ethnic Minor Psychol. 2005;11(1):28-40. https://doi.org/10.1037/1099-9809.11.1.28 PMid:15727493
7. Omenka OI, Watson DP, Hendrie HC. Understanding the healthcare experiences and needs of African immigrants in the United States: A scoping review. BMC Public Health. 2020;20(1):27. https://doi.org/10.1186/s12889-019-8127-9 PMid:31914960 PMCid:PMC6950921
8. Williams DR, Lawrence JA, Davis BA. Racism and health: Evidence and needed research. Annual Review of Public Health. 2019;40(1):105-25. https://doi.org/10.1146/annurev-publhealth-040218-043750 PMid:30601726 PMCid:PMC6532402
9. Jackson JS, Neighbors HW, Torres M, Martin LA, Williams DR, Baser R. Use of mental health services and subjective satisfaction with treatment among Black Caribbean immigrants: Results from the national survey of American life. Am J Public Health. 2007;97(1):60-7. https://doi.org/10.2105/AJPH.2006.088500 PMid:17138907 PMCid: PMC1716231
10. Evans N, Sheu JJ. The relationships between perceived discrimination and utilization of mental health services among African Americans and Caribbean Blacks. J Immigrant Minority Health. 2019;21(6):1241-7. https://doi.org/10.1007/s10903-018-0836-0 PMid:30460583

11. Jackson JS, Torres M, Caldwell CH, et al. The national survey of American life: A study of racial, ethnic and cultural influences on mental disorders and mental health. Int J Methods Psych Res. 2004;13(4):196-207. https://doi.org/10.1002/mpr.177 PMid:15719528 PMCid:PMC6878295
12. Turan JM, Elafros MA, Logie CH, et al. Challenges and opportunities in examining and addressing intersectional stigma and health. BMC Med. 2019;17(1):7. https://doi.org/10.1186/s12916-018-1246-9 PMid:30764816 PMCid:PMC6376691
13. Compton MT, Shim RS. The social determinants of mental health. Focus. 2015;13(4):419-25. https://doi.org/10.1176/appi.focus.20150017
14. Viruell-Fuentes EA, Miranda PY, Abdulrahim S. More than culture: Structural racism, intersectionality theory, and immigrant health. Soc Sci Med. 2012;75(12):2099-106. https://doi.org/10.1016/j.socscimed.2011.12.037 PMid:22386617
15. Boukpessi TB, Kpanake L, Gagnier JP. Why are African immigrants in Montreal reluctant to use mental health services?: A systematic inventory of reasons. Soc Psychiatry Psychiatr Epidemiol. 2024;59(9):1509-17. https://doi.org/10.1007/s00127-023-02566-1 PMid:37805584
16. Cabassa LJ, Molina GB, Baron M. Depression fotonovela: Development of a depression literacy tool for Latinos with limited English proficiency. Health Promot Pract. 2012;13(6):747-54. https://doi.org/10.1177/1524839910367578 PMid:21051325 PMCid:PMC3071859
17. Derr AS. Mental health service use among immigrants in the United States: A systematic review. Psychiatr Serv. 2016;67(3):265-74. https://doi.org/10.1176/appi.ps.201500004 PMid:26695493 PMCid:PMC5122453
18. Link BG, Phelan JC. Conceptualizing stigma. Annu Rev Sociol. 2001;27(1):363-85. https://doi.org/10.1146/annurev.soc.27.1.363
19. Wu R, Adeleke B, Pederson AB. Mental health knowledge and service utilization among black adults: Moderation by mental illness stigma. J Psychiatr Res. 2025;184:102-11. https://doi.org/10.1016/j.jpsychires.2025.02.014 PMid:40049116
20. Clark R, Anderson NB, Clark VR, Williams DR. Racism as a stressor for African Americans: A biopsychosocial model. Am Psychol. 1999;54(10):805-16. https://doi.org/10.1037/0003-066X.54.10.805 PMid:10540593
21. Williams DR. Stress and the mental health of populations of color: Advancing our understanding of race-related stressors. J Health Soc Behav. 2018;59(4):466-85. https://doi.org/10.1177/0022146518814251 PMid:30484715 PMCid:PMC6532404
22. Williams DR, Sternthal M. Understanding racial-ethnic disparities in health: Sociological contributions. J Health Soc Behav. 2010;51 Suppl(Suppl):S15-27. https://doi.org/10.1177/0022146510383838 PMid:20943580 PMCid:PMC3468327
23. Adzrago D, Thapa K, Rajbhandari-Thapa J, Sulley S, Williams F. Influence of biopsychosocial factors on self-reported anxiety/depression symptoms among first-generation immigrant population in the U.S. BMC Public Health. 2024;24(1):819. https://doi.org/10.1186/s12889-024-18336-w PMid:38491362 PMCid:PMC10941619
24. Delara M. Social determinants of immigrant women's mental health. Adv Public Health. 2016;2016(1):9730162. https://doi.org/10.1155/2016/9730162
25. Ibe-Lamberts K, Ajibewa T, Onyeise D, McNeil-Young V, Nmezi NA, Williams J. "I'm Black and I'm stressed": An exploratory literature review on stress and coping mechanisms among African Americans, Afro-Caribbean, and African immigrants in the USA. J Racial Ethn Health Disparities. 2025. https://doi.org/10.1007/s40615-025-02394-w PMid:40146467
26. Saasa SK, Rai A, Malazarte N, Yirenya-Tawiah AE. Mental health service utilization among African immigrants in the United States. J Community Psychol. 2021;49(6):2144-61. https://doi.org/10.1002/jcop.22602 PMid:34033683
27. Metzl JM, Hansen H. Structural competency: Theorizing a new medical engagement with stigma and inequality. Soc Sci Med. 2014;103:126-33. https://doi.org/10.1016/j.socscimed.2013.06.032 PMid:24507917 PMCid:PMC4269606
28. Jing F, Li Z, Qiao S, Ning H, Zhou S, Li X. Association between immigrant concentration and mental health service utilization in the United States over time: A geospatial big data analysis. Health Place. 2023;83:103055. https://doi.org/10.1016/j.healthplace.2023.103055 PMid:37311276 PMCid:PMC10527759
29. Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. PLoS Med. 2021;18(3):e1003583. https://doi.org/10.1371/journal.pmed.1003583 PMid:33780438 PMCid:PMC8007028
30. Ayele SG, Thompson-Robinson M, Andrews J, Dodge Francis C. Factors associated with mental health service utilization among Ethiopian immigrants and refugees. J Immigr Minor Health. 2020;22(5):965-72. https://doi.org/10.1007/s10903-020-00984-w PMid:32130570
31. Ho MJ, Gosselin K, Chandratilake M, Monrouxe LV, Rees CE. Taiwanese medical students' narratives of intercultural professionalism dilemmas: Exploring tensions between Western medicine and Taiwanese culture. Adv Health Sci Educ Theory Pract. 2017;22(2):429-45. https://doi.org/10.1007/s10459-016-9738-x PMid:27888427
32. Orjiako OEY, So D. The role of acculturative stress factors on mental health and help-seeking behavior of sub-Saharan African immigrants. Int J Cult Ment Health. 2014;7(3):315-25. https://doi.org/10.1080/17542863.2013.797004
33. Tanwani HAA. Sub-Saharan African immigrants' experiences in utilizing mental health services in Baltimore [PhD thesis]. Minnesota, MN: Walden University; 2023.
34. Venters H, Adekugbe O, Massaquoi J, Nadeau C, Saul J, Gany F. Mental health concerns among African immigrants. J Immigr Minor Health. 2011;13(4):795-7. https://doi.org/10.1007/s10903-010-9357-1 PMid:20549358
35. Edem-Enang B. African immigrants' U.S. experience of mental health, mental illness, and help-seeking [PhD thesis]. Minnesota, MI: Walden University; 2021.
36. Hall-Clifford R, Uehling M, Khan H, , et al. Community-led identification of mental health support, challenges, and needs among Ethiopian immigrants to the U.S.: Opportunities for partnership with faith communities. Ment Health Relig Cult. 2023;26(9):829-49. https://doi.org/10.1080/13674676.2023.2282089
37. Myers N, Meeker R, Odeng V. Pastors as partners in care: African immigrant pastors' on mental health care referral processes for young congregants experiencing symptoms of psychosis in the US. Commun Ment Health J. 2025;61(1):138-46. https://doi.org/10.1007/s10597-024-01335-x PMid:39162968 PMCid:PMC11703927

38. Deng Y, Rose T. Examining dimensions of help-seeking intentions and associations with personal mental illness stigma among racial and ethnic minority immigrants. J Commun Psychol. 2025;53(2):e23154. https://doi.org/10.1002/jcop.23154 PMid:39370301
39. Pederson AB, Waldron EM, Fokuo JK. Perspectives of Black immigrant women on mental health: The role of Stigma. Womens Health Rep (New Rochelle). 2022;3(1):307-17. https://doi.org/10.1089/whr.2021.0071 PMid:35415711 PMCid:PMC8994434
40. Tekeste M. Ethiopian Immigrants in the US: the Implications of Perceived Public Mental Illness Stigma and Mistrust of Mental Health Providers for Mental Health Help-Seeking Intentions [Internet] [Ph.D.]. [United States -- District of Columbia]: The George Washington University; 2022 [cited 2025 May 8]. Available from: https://www.proquest.com/docview/2713477208/abstract/8F1DCB5D1D454A58PQ/1
41. Boundaoni IA. Health Care Access and Utilization among African-Immigrants in the District of Columbia Metro Area in the United States: A Comparative Analysis [Internet] [D.P.A.]. [United States -- Maryland]: University of Baltimore; 2015 [cited 2025 May 8]. Available from: https://www.proquest.com/docview/1737843591/abstract/97EAF94CE2BC4249PQ/1
42. Pederson AB, Tsai AC, Hawkins D, Moskowitz JT, Dixon L. Understanding the association between mental health knowledge and mental health service utilization among Black adults. Commun Ment Health J. 2023;59(1):57-67. https://doi.org/10.1007/s10597-022-00988-w PMid:35794413 PMCid:PMC10371774
43. Jegede O, Na PJ, Rhee TG, Stefanovics EA, Rosenheck RA. Psychiatric and substance use disorders and related service use in the diverse Black sub-populations in the United States. J Racial Ethnic Health Disparities. 2022;9(6):2237-47. https://doi.org/10.1007/s40615-021-01163-9 PMid:34590245
44. Akresh IR. Health service utilization among immigrants to the United States. Popul Res Policy Rev. 2009;28(6):795-815. https://doi.org/10.1007/s11113-009-9129-6
45. Mohammadifirouzeh M, Oh KM, Basnyat I, Gimm G. Factors associated with professional mental help-seeking among U.S. immigrants: A systematic review. J Immigr Minor Health. 2023;25(5):1118-36. https://doi.org/10.1007/s10903-023-01475-4 PMid:37000385 PMCid:PMC10063938
46. Miller GH, Marquez-Velarde G, Emoruwa OT, et al. Racial context and health behaviors among Black immigrants. J Racial Ethnic Health Disparities. 2023;10(5):2218-30. https://doi.org/10.1007/s40615-022-01401-8 PMid:36216979
47. Cerda IH, Macaranas AR, Liu CH, Chen JA. Strategies for naming and addressing structural racism in immigrant mental health. Am J Public Health. 2023;113(Suppl 1):S72-9. https://doi.org/10.2105/AJPH.2022.307165 PMid:36696610 PMCid:PMC9877373
48. Niameh FV. First generation West African Americans' experience of mental health service seeking and utilization in the United States [Internet] [Psy.D.]. [United States -- California]: John F. Kennedy University; 2013 [cited 2025 May 9]. Available from: https://www.proquest.com/docview/1459228117/abstract/AD90B3F1BF04422DPQ/1
49. Villatoro AP. Perceived need for mental health care among racial/ethnic minorities and non-Latino Whites in the United States [PhD thesis]. California: University of California, Los Angeles; 2014.
50. Kpanake L. Cultural concepts of the person and mental health in Africa. Transcult Psychiatry. 2018;55(2):198-218. https://doi.org/10.1177/1363461517749435 PMid:29400136
51. Whaley AL. Help-seeking from indigenous healers among persons of African ancestry in the United States: Ethnic and racial disparities in mental and physical health. Complement Ther Med. 2019;45:222-7. https://doi.org/10.1016/j.ctim.2019.07.005 PMid:31331565
52. Yusuf KK, Madu E, Kutchava S, Liu SK. The coronavirus (COVID-19) pandemic and mental health of African immigrants in the United States. Int J Environ Res Public Health. 2022;19(16):10095. https://doi.org/10.3390/ijerph191610095 PMid:36011724 PMCid:PMC9407718