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Beyond mental health stigma: Youth leaders' voices through an African theology of hospitality

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Abstract

The intersection of youth mental health and theological reflection and praxis is critical yet scarce within African contexts. Public health evidence shows the prevalence of mental health crises, and this evidence is usually limited to healthcare contexts such as hospitals or within public policymaking. In the backdrop of the COVID context of psychological, social and cultural displacements of young people, the effects on mental health are deleterious. This paper isolates mental health stigma through a mixed-methods analysis of data from 187 Kenyan emerging adults (19 to 29 years old) and 9 youth pastors in diverse Christian congregations. The paper shows that youth workers (or pastors), as directly involved in providing ministry to young people, serve as catalysts in the church's response in fostering mental health wellbeing. This paper (1) provides empirical evidence of the prevalence of mental health issues among emerging adults in Kenyan congregations (2) examines the African contextual issues that lead to stigmatisation of young people undergoing mental health adversities, and (3) proposes a theology of hospitality that can be integrated within youth ministry models as a decolonial intervention for building better mental health resilience. The paper broadly shows how science (psychology) engaged theology can serve as a resource for interrogating social and psychological realities facing communities of faith, and lead to more hope-giving theological practices for leading young people homeward, towards psychological flourishing.

Keywords

practical theology; psychology of religion; science-engaged theology; theology and mental health; theology of hospitality; mental health; youth

Stigma and theolog(ies) of mental health

Mental health is an increasing concern within Christian communities. Existing literature shows that within both global and African contexts, those struggling with mental health are stigmatised. It is common to connect mental illness with a lack of spirituality or insufficient faith (Swinton 2024; Van Ommen 2019). The source of stigmatising mental health is based on over spiritualizing mental illness or uncritically engaging with underlying African perceptions of illness as taboo (Ndlovu 2016; Swinton 2024). Departing from the greatest commandment of love, stigma is also expressed through either blaming individuals for their mental illness or excluding them from the Christian community (Lehman 2021). This research further extends this literature on mental health stigma by critically engaging with an African theology of hospitality in the context of youth mental health issues in the Kenyan context. This can only happen by retrieving the role of congregations in fostering better mental well-being and resilience.

Congregations as social networks of people who share mutual belief can be avenues for fostering mental health awareness, knowledge and resilience, or barriers against them (Jakob and Weyel 2020). Fostering such self-awareness for mental health needs among the congregation's members is premised on the theological understanding of the Church. As the gathered community of God's people, in a journey of redemption through the salvific acts of God made manifest through the eternal Word and visibly through the Sacraments, the Church is a community of those on the journey of being made whole. Mental health in this paper is understood as the emotional and psychological aspects of a person's overall sense of well-being, which are a factor of individual traits, communal socialisation, and premised on religious and spiritual identities and beliefs (Rosmarin and Koenig 2020). Thus, Susanta (2025) views the Church as a "field hospital".

However, following this imagery from Susanta, the Church can also be a site of further injury. The church can injure those with mental health needs, which includes all of us, when it stigmatises persons who suffer from mental health disorders. Especially in the African context, mental disorders can easily be attributed to a lack of faith, a consequence of bad omen or as a psychotic episode (Asamoah, Osafo and Agyapong 2014; Osafo 2016; Mligo 2021). Given the cosmological framework of Africans

that makes room for supernatural forces, Asamoah, Osafo and Agyapong's (2014) research among Pentecostal clergy reveals that mental health challenges are seen as a distortion caused by an evil supernatural presence. Responses to these challenges within such settings commonly takes the forms of exorcism, health education and social support, depending on the primary cause of mental health (Asamoah, Osafo and Agyapong 2014). Thus, some African approaches to mental health stigmatise these disorders as a deviance resulting from divine and ancestral punishments (Ndlovu 2016:32). Given that African cultural worldviews define much of Christian congregational life, these notions of stigma continue to shape mental health responses in communities of faith. Considering this, a theology of mental health is needed.

The terrain of theology and mental health is well-trodden. Watts (2018) and more recently Swinton (2024) provide two exemplary overviews on theological responses to mental health phenomena – the former by a psychologist of religion, and the latter by a practical theologian. Thus, their two summaries are helpful for our present discussion. Considering the varieties of emotional and psychotic disorders, Watts (2018:337) helpfully observes the broadness of "mental health" itself and argues that it is possible to over-simplify, or under-conceptualise mental health, as is evident in some cases in the recent literature on the two fields. Watts (2018:337) also helpfully moves beyond the initial Christian discourses of mental health from the perspective of "moralistic framing" or "sinful". Citing Bavidge (1989), Benner (1988) and Beer and Pocock (2006), he explains that such perspectives usually label mental health sufferers as those who are either bad or mad. To respond to this moralistic framing, he proposes a unique science-religion framing of the discussion. This proposal moves beyond theology being the primary interlocuter, to a more balanced perspective between science and theology (used interchangeably with religion), in his own words (Watts 2018:338):

> The relevant sciences (psychology, psychiatry, and neurology) are compatible with a religious perspective, and together they provide complementary perspectives that enrich our overall understanding.

Watts uses this perspective to look at the scientific and spiritual factors that may underlie emotional disorders such as schizophrenia, with both

domains of knowledge having a compatible relationship. Scientific research has shown a positive correlation between spirituality or religion and mental health outcomes (Bhugra, Mosqueiro and Moreira-Almeida 2021:1). Other research has also shown that integration of spirituality in healthcare practices is critical in fostering better mental health outcomes as well as providing holistic, compassionate and respectful care (Bhugra, Mosqueiro and Moreira-Almeida 2021:2; Ndereba 2024).

Swinton (2024:1) also complements Watt's perspective by observing how the historical development of the relationship between theology and mental health was based on both conflict and cooperation. He shows how the conflict thesis, operating within the discourse of theology and mental health, led to an over-spiritualisation of mental distress as either "attributed to divine punishment, demonic possession, or spiritual warfare" (Watts 2024:1). This is especially applicable within many African contexts, where the cosmological and ontological underpinning are over-handedly attributed to or predetermined by spiritual and higher beings including spirits, vital forces, gods or even ancestors (Cook 2024; Humbe 2020). However, latching back to the history of the 18th and 19th centuries, Swinton (2024:2) shows how the purely naturalistic accounts of mental health discernible in contemporary life can be traced to the Enlightenment. He also shows how in the 20th century, both psychologists like Carl Jung and Viktor Frankl, and pastoral theologians, such as Seward Hiltner and Howard Clinebell, correlated psychological insights with religious and spiritual perspectives.

Swinton then discusses various themes that theologies of mental health today are taking or should take. Two of them are central to this paper, as they enlarge the positionality of this research:

> Theologies of mental health must consider the social and systemic aspects of mental disorders. He engages with Cross (2024:9) to discuss how social media negatively impacts mental health outcomes of young people, and how "embodiment" – as a theological category of the imago Dei, the incarnation and the invitation to live in relationship with others – may be a solution. Summarising Cross's major argument and drawing from the Psalms, Switon (2024:5) says that "individual flourishing [is located] within the context of community flourishing."

Theologies of mental health must be embedded in other global contexts: Swinton (2024:7) critically observes that the existing literature in theology and mental health is heavily skewed towards Western and Anglo-American contexts.

This agenda to expand with an aim to centre global South contexts is what Kamwendo (2024) calls "decolonising science-engaged theology". It is often the case that theologies of mental health as a sub-set of science-engaged theology are often grounded within western discourses, modernistic notions of short-sighted conflict narratives of faith and science, and canons of literature and authority figures, written for and from privileged contexts. Kamwendo (2024:25) defines "decolonisation" as a "querying of the benchmarks set by the hegemony of Western modes of thinking." It asks us to question the authority of knowledge claims, particularly from whom that authority derives and why. This paper moves beyond mere questioning by making a proposal that African theological thought and scholarship provide us with rich fodder and wisdom to engage with mental health realities in our unique, albeit slightly different, context.

Methodology

This paper zeroes in on a specific issue of mental health in the Kenyan context: stigma. The research used a contextualised, 25-item resilience scale developed by Wagnild and Young in 1993 and validated in 2009 among 187 emerging adults (19 to 35 years old youth) in select and diverse congregations. To triangulate the data, this research conducted focused group discussions (FGD) with 9 youth pastors from these select congregations: Presbyterian Church of East Africa (PCEA), Anglican Church of Kenya (ACK), African Independent, Pentecostal, Evangelical and also gender diversity (4 females, 5 males); geographic scope (Nairobi, Kajiado, Bondo, Embu, Nyeri, Nakuru) and mixed rural and urban dynamics. Ethical clearance was provided by St. Paul's University, the primary investigator's and this paper's author's home institution.

Findings on the stigmatisation of mental health

The study included 187 participants, with a near-equal gender distribution (51.9% female, 48.1% male). Most respondents were aged 18-23 years (63.6%), followed by 24-29 years (33.2%), indicating that the sample predominantly consists of emerging adults. In terms of religious affiliation, 35.3% identified as Other Protestant, while 24.1% were Presbyterian. Most participants were students (61.0%), and the most common fields of work or study included Construction, Engineering & Technology (26.2%), Business, Finance & Management (21.9%), and Health, Medical & Sciences (15.5%). Additionally, 89.3% of participants had been Christians for more than 5 years. The research was designed to map mental health challenges in Kenyan churches and the following findings emerge from the qualitative analysis conducted through NVIVO and the quantitative analysis conducted through R:

Prominent disorders

The two most prominent disorders were anxiety and mood disorders. Specifically, depression, drug addiction, ADHD, loneliness and isolation were among the disorders mentioned. All the interviewed youth pastors acknowledged the reality of mental health issues among the young people in their church ministries.

> P1 – Many youths are depressed and need mental health attention.
>
> P2 – I also do community work with youths who are struggling with drug addiction and mental issues in collaboration with the rehabilitation centres around and the general hospital in the psychiatric ward.
>
> P3 – Here in Eastern Kenya, so many youths are suffering from drug addiction.
>
> P4 – Having worked with youths, mental health awareness is very important for the following reasons:
>
> > Several youths have various mental disorders.
> >
> > Youths are vulnerable to mental illness.

The youth ministry could help identify mental health concerns among youth.

P5 – Just last week, I had a friend of mine, and we were discussing some of these issues and how the son, who is a lawyer, now started having some behaviour changes and he isolates himself and he has become very difficult until lately he started cutting himself with a razor. There's a time he actually wanted to commit suicide. And when she finally decided to take the son to the hospital, he was diagnosed with ADHD.

From the quantitative analysis, the graph below shows the distribution of mental health disorders among either their respondents or their peers. One of the questions asked whether they or a friend they know has suffered the mental health disorders listed below. This approach helped to destigmatise their participation in the research and to ensure safety in naming the specific mental health disorders they or their peers are facing:

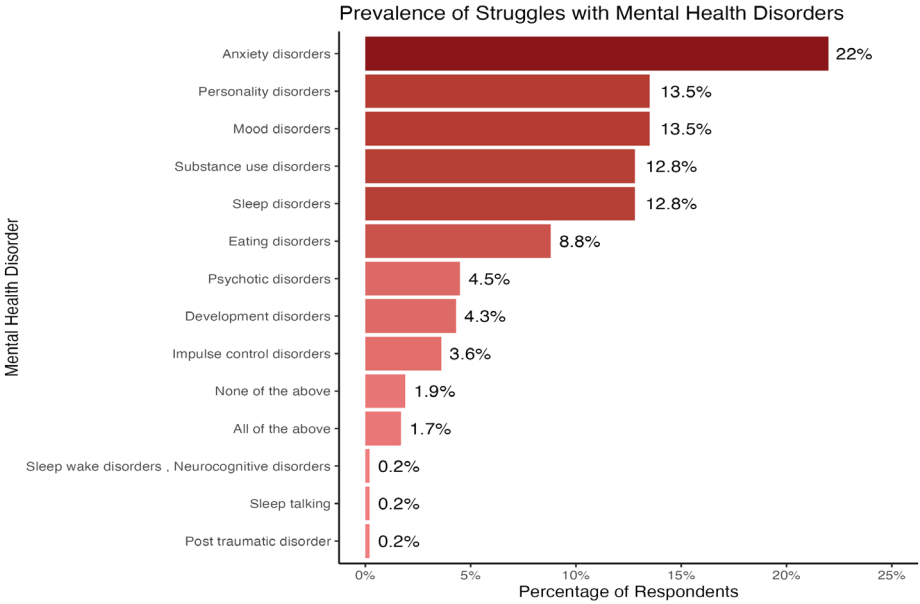

Figure 1: Distribution of mental health disorders experienced by respondents or peers

The findings on the prevalence of struggles with various mental health disorders among respondents or their peers, comport well with other existing literature and data. The graph shows that anxiety disorders were the most frequently reported, affecting 22% of participants or their peers. Personality disorders (13.5%) and mood disorders (13.5%) were also commonly cited, followed by substance use disorders (12.8%) and sleep disorders (12.8%). Eating disorders (8.8%), psychotic disorders (4.5%), and developmental disorders (4.3%) had lower prevalence rates. Additionally, impulse control disorders (3.6%) were reported by a small proportion of respondents. A minimal percentage (1.9%) indicated experiencing none of the listed disorders, while post-traumatic disorder, sleep-wake disorders, neurocognitive disorders, and sleep talking were reported by only 0.2% of respondents each.

Stigmatisation

From the youth pastors' FGD, stigmatisation stems from a lack of knowledge, both from the young people who cannot fully name their condition, and from the churches and church leaders who are not aware of mental health categories or how to address mental disorders.

> PB – My interest in this research is basically on my personal passion in bridging the knowledge gap among the young people that will help to empower them and maybe reduce stigma to mental conditions.
>
> PE – But I've seen those who are suffering these things, who I easily spotted early, are stigmatised, like they don't think that they have a problem. Sometimes I wonder, is it in my place to tell them that they are in a problem and you're in a dilemma because they're in a place where they are resistant. And then you also don't want a case where their parents come after you. So, I'm normally caught in that place of not knowing how to help them.

Secondly, stigma arises from the fact that young people are afraid of seeking help, as this is seen as a lack of strength.

> P1 – At this point, there's still that stigma of trying to show, of trying to ask for help, or even realising you have a problem. I've noticed that a few of them also suffer from things like bipolar, but they do not

even understand.

Third, stigma arises from the over-spiritualisation of mental health phenomena, which is common within the African worldview contexts that make room for supernatural reality as part of its cosmology.

> PD – The subject or the topic of mental wellness amongst the young people, especially in the church, is very critical because the church, quote unquote, has been labelled as one of the most discriminative institutions when it comes to matters of mental illness, because of that issue of too much spiritualism, which kind of we see people who are having challenges with mental issues like they're demon possessed.

On the other hand, one respondent observed that emotional processing is not common within African society at large. This can be attributed to the honour-and-shame culture, so common within African societies, and which may "demonise" certain issues or discussions as taboos within the wider community. Based on kinship structures in society, this may further contribute to stigmatisation when it comes to mental health issues.

> PF – Stigmatising means you don't even say that you have a problem with your emotions, or the issue about therapy does not come up in the African context. It's seen as a taboo in the African context. So, I think also that we are serving in a context that is African, and at the same time, it's a church.

> PH – I think our young people need this outlet to be able to speak out about whatever is going on in their hearts without being judged.

> PI – There's a lot of discrimination and a lot of stigmatisation about people who are suffering from mental health issues. And you find that, especially we people who are people of faith, we want to hide the real situation of our lives rather than seeking help, especially medical treatment. I have several cases where you find, maybe because I am a reverend or a pastor, and my child is going through mental health issues, I would rather keep them, I would rather pray for them than seek medical help. Then later, when the situation has worsened, that's when we rush to the hospital. Just last week, I had a friend of mine, and we were discussing some of these issues and how the son,

> who is a lawyer, now started having some behaviour changes and he isolates himself and he has become very difficult until lately he started cutting himself, cutting himself with a razor. There's a time he actually wanted to commit suicide. And when she finally decided to take the son to the hospital, he was diagnosed with ADHD – which is a condition that requires treatment.

Knowledge gap

The research findings show that a lack of knowledge and awareness of mental health is a factor in the implementation of appropriate interventions from the church. Lack of knowledge can either be from the young people, in such a way that would prevent them from accessing mental health diagnoses and support.

> P6 – Because many youths who are depressed and who need mental attention, but because of the context in which we are serving in, they're not quick, even though they know they need assistance.

> P12 – I've seen those who are suffering these things, who I easily spotted early, are stigmatised, like they don't think, or rather, they don't think that they have a problem.

Secondly, the knowledge issue was also a concern for church leaders and youth workers. When they lack the necessary knowledge, they are consequently unable to provide the necessary leadership to seek mental healthcare interventions within the context of local congregations.

> P13 – The church should ensure its clergy are trained professionally to handle mental health cases.

Third, the research shows that youth leaders who are closer to the young people who are struggling with their mental health have a positive attitude when it comes to knowledge of mental health. This knowledge derives from their community engagement in working with young people in the family setting, rehabilitation centres and other similar community organisations, for instance:

> P8 – I also do community work on working with youths who are struggling with drug addiction and mental issues in collaboration with the rehabilitation centres around and the general hospital in

> the psychiatric ward. And this research has come at the right time, so that we can understand the issues that push the young people to these mental challenges and issues, and then we can come up with strategies on how to help them with knowledge and skills.
>
> P11 – And having had cases of bipolar, of close relatives, I was able to mark, or rather see, symptoms early when I would interact with the youth, some of them, like emotional outbursts. They're very, like, sometimes just extremes of the emotions. And you can see, even as you're talking with the youth, you can see there's something that they need to do counselling, or rather, they need to do therapy. So, the good thing is, in the church where I'm serving, we have a counselling department, and I have seen several youths go through the department recently, go through the counselling class recently, and it has really helped them.

Finally, youth leaders revealed an openness to learning more about mental health to further facilitate mental health resilience.

> P7 – And my interest in this research is basically on my personal passion in bridging the knowledge gap among the young people that will help to empower them, and maybe reduce stigma to mental conditions.
>
> P10 – It will help me so much in gaining more knowledge on how to deal with the mental issues we are having with our youth. More so in Eastern, so many youths are suffering from drug addiction. And so, I know this group will help me on how to deal with them and how to deal with their mental issues.

The youth pastors understand mental health resilience to be a dynamic and flexible process involving several aspects:

a. A process of change: almost all respondents defined resilience as a process and not as a time-bound status.

b. Beginning with self-awareness: the respondents noted the agency that young people have in addressing their mental health issues. This awareness was expressed in terms of "identifying", "accepting",

"processing", "assessing" and "changing" one's viewpoint or perception.

c. Moving through a sort of barrier: defined as "chaos", "threats", "illness", or "addiction".

d. An end goal in mind: this was defined not as the eradication or simplistic resolution of the barrier, but in terms of "healing", "recovery", "coping", and "strength".

P1 – Mental health resilience is the ability to accept and move on despite how life presses you.

P2 – Ability to be of a sound mind amidst chaos and in all prevailing circumstances.

P3 – perseverance in the face of realities of potential threats to one's mental health, processing and assessing the veracity of said threats, and biblically addressing the issues consistently; bringing every thought captive and subjected under the feet of Christ.

P4 – Mental resilience is the process of adapting to accept, change and recover.

Finally, the youth leaders, beyond their willingness to learn, propose various interventions. These interventions can be split into two: church-related interventions and church-and-community-related interventions. The first one has to do with the self-understanding of the church in its spiritual and teaching mandate. For instance, one youth leader argues that mental health should be included as part of the process of catechism within mainstream traditions like PCEA and ACK, which practice this as part of the confirmation rites of the church.

P14 – For us in the mainstream churches, when we are doing the catechism and introducing matters faith to the young people, which starts from the adolescents all the way before they get into the youth, that would be a very good period for the church to also introduce the topic on mental health, because that's when the young people or the adolescents, the teens are going through so many changes in their bodies, emotionally, socially, you know, they some of them they suffer from identity crisis, some of them issues of self-esteem, and the same way we introduce faith to these children, the church can also play

> a key role in introducing these topics and by holding seminars and sometimes to craft sermons and topics that are based on the mental wellness of the young people so that as they go the process of changes in their development, they may also be in a position to be aware of who they are, why these things are coming in their way, and as much as they learn them from school, the church can take the role of emphasising this.

Another youth worker also observed the role of ongoing training and seminars for church leaders and members that can close the knowledge gap. Additionally, specific church practices of lamenting and church ministries such as youth ministries, preaching ministries and counselling ministries are seen as platforms for fostering better mental health outcomes for young people undergoing mental distress:

> P11 – So the good thing is, in the church where I'm serving, we have a counselling department, and I have seen some youths go through the department recently, go through the counselling class recently, and it has really helped them.

> P14 – The church can also play a key role in introducing these topics and by holding seminars and sometimes to craft summons and topics that are based on the mental wellness of the young people so that as they go the process of changes in their development, they may also be in a position to be aware of who they are, why these things are coming in their way, and as much as they learn them from school, the church can take the role of emphasizing this.

> P15 – Also conducting training and encouraging open conversations on mental health. Where possible, having an empowered department/ standing committee on mental health.

> PR – I have seen in times when we were having the Gen Z, the protests and the issues, killings and all. We had sessions where we just came together to lament, you know, as a spiritual practice. Yes, we were praying for justice, but we were also just lamenting the brokenness that we see in our context and believe that we prayed regarding just the Lord's intervention.

The second aspect of the proposed interventions has to do with the church outside the four walls. In other words, youth pastors also acknowledged the role of the church within the community by partnering with similar youth-serving organisations to deal with mental health:

> P22 – By creating a counselling centre just to engage these young people.
>
> P24 – To create a social working environment for the young, since the church should be at the heart of the young people.
>
> P36 – Counselling centres and you know, like it is at that point in every church, if you have the youth centre, youth-friendly centres, like the way the VCT, they have youth in the city centres, we also have them in our churches. And at that point now, we can bring in the professionals that are in our churches so that we can help identify which case needs just mentorship, which other one needs counselling, which other one needs to be referred to a medical facility, so that these young people can be helped. It is calling upon many players and professionals in the congregation for the holistic management of mental health issues amongst the young people.

Moving to the normative aspect, this paper observes that the three key emerging issues from the empirical data require a formulation of a theological response that can guide practical interventions within local congregations in the Kenyan, largely African, contexts. The following sections provide biblical and African theological perspectives on hospitality as a theological framing that can strengthen integration of mental health responses to stigmatisation within the church.

Biblical perspectives on hospitality

The pertinent Old Testament language of "stranger" – גֵּר) ger) – needs further clarification. It does not mean simply "a person or thing that is unknown or with whom one is unacquainted", but specifically a "sojourner, resident alien" (see further below). Martin (2014) argues that the term זָר) zar) would be used for "stranger" in the sense of unknown or unacquainted – the participial form from זרה') to be a stranger either to a family (i.e. of another household), person, land, or law (meaning against

one's expectation for the laws of nature) (see BDB זרו Qal, Pt., p. 266). Cf. יְנֵכְרִי nokri), 'foreigner', from the second definition for רכנ, which directly opposes its first definition as the one recognised, or with which one is acquainted (see BDB רכנ II substantive adj., p. 648). Abraham is used as a paradigmatic example of how hospitality is expressed beyond one's own needs to focus on the needs of the other (Moyaert 2011).

Melton (2023:119) argues that what becomes clear from surveying multiple Old Testament texts regarding host and guest is that hosting entails two key components: provision and protection. Expressions of hospitality in the OT (Melton 2023) include:

- a greeting with bow or kiss (Gen 18:2; 19:1).
- a welcome for the guest to come in (Gen 24:31).
- an invitation to rest (Gen 18:4; Judg 4:19).
- an opportunity to wash (Gen 18:4; 19:2; 24:32)23.
- a provision of food and drink (Judg 4:19; 19:5)24.
- an invitation to converse (Gen 24:33).
- a provision of security (Gen 19:8).

These actions are not just between human beings but are primarily expressed by God to his people – this is seen in the provision of manna and quail in the wilderness, shepherding his people through Israel's exilic experience and the safe passage within the neighbouring nations (Pohl 2024). These Old Testament passages connect with the New Testament concepts of hospitality.

Anderson's discussion of the New Testament vocabulary of hospitality is clarifying here. Of the four main lexical groupings of New Testament vocabulary on hospitality, the first is the most pertinent for its connection with גֵּר in the Old Testament. Derived from the Greek root ξεν-, it includes ξένος (xenos), meaning "stranger", "foreigner", "outsider", or "host". The most direct translation of "hospitality" from the Greek comes from this group, φιλοξενία (philoxenia), more literally rendered as "love of the outsider". The fourth group is also relevant, made up of the actions of hospitality – "eating, providing lodging, foot-washing, serving, equipping for further travels", etc. These practices of hospitality are central to the

Christian communal and missional actions in the early church. African practices of hospitality also connect with these biblical images of hospitality.

Hospitality in African theology and philosophy

Hospitality is a central aspect of African life and society, usually passed through folklore and practical familial life (Aihiokhai 2017). A practical way in which this is seen in daily life is when one family visits another family. Family in the African setting not only includes the nuclear family but is connected through kinship structures to the extended families and wider community. When families visit, they usually carry with them gifts to leave in the home that is visited. In fact, some African proverbs say that it is not good to go to a neighbour's house empty-handed.1 This illustrates the concept of giving in African culture and philosophy. Hospitality can be defined in several ways:

1. That extension of generosity, giving freely, without strings attached (Gathogo 2008:3).
2. An unconditional readiness to share (Echema 1995:35).
3. A free space where the stranger can enter and become a friend instead of an enemy. Hospitality is not to change people, but to offer them space where change can take place (Hernandez 2015:93).
4. It is an offer, and it renders unconditional respect and awards an honour that empowers others, as they certainly deserve the respect due to their dignity, having been made in the likeness of God (Magezi and Khlopa 2021).

Gathogo (2008) notes the close linkage between African philosophy and the concept of African personality and being (ontology) as well as the African concept of community (ubuntu). As such, hospitality is still palpable within African life even in the face of postmodern changes affecting African societies. Even when it comes to the concept of resilience, Nanthambwe (2024) claims that:

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1 An example of an African proverb emphasising hospitality is: If you go to your in-laws, you do not come back empty-handed but with a cock.

> In theological contexts, resilience is conceptualised as a spiritual and communal strength. It is grounded in faith, where religious beliefs, practices, and community support contribute significantly to resilience. Religious traditions like prayers, rituals, and spiritual practices provide frameworks for meaning making and support, aiding individuals and communities in overcoming adversity

Magezi and Khlopa (2021:18) argue that hospitality is a twin to ubuntu and observe that it seeks the well-being of the other as it is grounded in the dignity that people have created in God's image. They focus their conversation on pastoral care approaches that can lead to the transformation of their South African community and propose that simple acts of hospitality to strangers, immigrants, the vulnerable, poor and others on the margins of society can be powerful expressions of hospitality. Louw (2014:24), taking on this public-facing role of hospitality, notes that integrated in spirituality, hospitality can widen caregiving within public domains where there are diversities in ethnicity, race, sexuality and religion, among other differences. Elsewhere, Louw (2014:34) says:

> Hospitality and how one deals with the stranger or outsider could be viewed as one of the cornerstones of a praxis of caregiving in the Christian tradition of comfort and compassion.

This reflection is poignant for the task of youth ministry today. While young people are a key demographic in African villages and cities, they are often presumed, neglected, abandoned or oppressed. Politically and economically, in their youthful stage, they do not yet have sufficient socio-economic mileage to influence key decision makers in a variety of countries. Politicians noting this gap are known for mobilising impressionable young people to do their bidding. Secondly, culturally, they are at the bottom of the "value chain" when it comes to their role in society. The ancestors and living dead continue to occupy important roles in African cosmology and society, and then the elders of the community and finally women and children.2 Third, within religious and psychological thinking, young people are undergoing a process of identity formation or "identity

2 Interestingly, it is a common setting for young adults and adults to be referred to as children by the elders, even though children in several national policies and protocols define children as those aged 12 years and under.

discovery", to use Aziz's (2019) words, individuation and the questioning of inherited religious values and perspectives. These three factors inform the place and role of young people within African society. If one considers the tense socio-political issues affecting countries like Ethiopia, Nigeria and South Sudan, it is easy to see how young people are marginalised.

From a pastoral perspective, this means that young people navigate their journey to adulthood abandoned, ashamed and alone. Additionally, intellectual and spiritual forces at play seek to dehumanise them and to sway them from God's abundant vision. These forces are all directed against the well-being, dignity, spirituality, and psycho-social contexts of young people. The required pastoral and theological responses will remain handicapped if they focus on individualistic and reductionistic approaches that focus on one aspect of the above and not the others – which seems to be the way some of the classical models3 of youth ministry are geared.

Implication and models of engagement

Summarising the two aspects of hospitality as provision and protection, this paper proposes two implications for youth ministry practice. First, churches should provide a safe space for youth to grapple with mental health challenges. This paper follows the thinking of Susanta (2025), who, writing on mental health and the church in the Indonesian context, argues that "the church also has an active responsibility to 'be a real sanctuary for those struggling with mental health issues', because that is its divine and pastoral calling." This paper shows that the church in Africa, and Kenya in particular, is engaging with young people who are undergoing a variety of mental health challenges. These include anxiety and mood disorders, such as depression of bipolar disorders. Thus, the church should not only focus on spiritual cures for these mental health challenges but also offer spiritual comfort and presence for people undergoing these challenges. This would significantly address the stigmatisation often associated with mental health, as this paper has shown from the qualitative data analysis. Rather than socially distancing those who struggle with mental illness, the

3 I use "models" of youth ministry to refer to the approaches towards practical youth ministry. For discussion on such models, see Griffiths (2013) and Weber (2017).

church should welcome them into its ministry and engage compassionately with healthcare professionals to provide the necessary support.

Second, churches should protect the mental well-being of youth with the necessary and holistic care. This paper moves beyond the traditional theologies of mental health as either moralising mental health or seeing the faith-science dialogue in terms of conflict. It proposes a middle way of dealing with mental health challenges through both spiritual resources from church leaders and scientific interventions from healthcare workers. This is especially critical given the stigma that arises from African concepts of taboos and curses. Moving beyond a dichotomy between the scientific and the spiritual, or the church versus the hospital, this paper proposes an integrated approach to dealing with the mental health of young people. The findings of this paper show that young people acknowledge that spiritual practices such as worship, prayer and communion or fellowship strengthen mental health resilience. On the other hand, they note the wrong concern of over-spiritualizing mental health challenges that can be resolved through medical or healthcare intervention. Thus, through the empirical analysis of the data, this paper shows that spirituality and science can go hand in hand, particularly within African contexts that eschew reductionistic accounts of scientific materialism and individualism. The church, as a community of care, can provide a more integrated solution to the reality of mental health. The research revealed the need for integrating approaches to young people, where churches partner with community health centres and academic centres, for the purposes of knowledge sharing, and continuous learning and training of church leaders.

Conclusion

This paper has provided a theology of mental health from the perspective of qualitative data analysis of youth pastors who care for young people. The larger quantitative analysis is presented in another research, so this paper limited itself to the qualitative analysis of the data from the youth leaders in the research. This choice is intentional as it seeks to prime the voices of young people and their leaders in the Church. Being that they are the ones directly working with young people, they can provide a good linkage between the Church's leadership and the young people served in their youth

ministries. This paper has shown the prevalence of mental health challenges among emerging adults in Kenya. It is envisioned that similar trajectories may be the case within other African geographical contexts, if the study's scope is expanded in future research. Secondly, the paper is embedded within African practical theologies of hospitality, which is another way of broadening the scope of mental health research beyond the Western and North American contexts. Hospitality within African thinking has been conceptualised as protection and provision, and this paper has applied this thinking to practical youth ministry models. This dual role of the Church in caring for young people with mental health involves providing safe spaces and protecting young people's mental health through integrating spiritual and pastoral resources with scientific and medical interventions. This balance would dissolve the dichotomies that hinder holistic mental healthcare in faith communities, by grounding mental healthcare within the spiritual resources that Christian faith provides, while also avoiding the over spiritualizing or moralising that prevents Christian youth from receiving needed medical treatment. Practically, this means that the Church will provide a space for healthcare workers in their communities of faith, while also partnering with other community organisations, thereby allowing the Church to be the Church in community. This would be a practical example of the Church being hospitable to the society within which the Church is located.

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