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Cultural factors shaping help seeking for mental disorders among family caregivers in Harare, Zimbabwe

*B Dube [1], M Chiweshe [2] and J Mapara [3]

1. University of Zimbabwe, Faculty of Medicine and Health Sciences, Department of Mental Health. Harare, Zimbabwe

2. University of Zimbabwe, Department of Community and Social Development. Harare, Zimbabwe.

3. Chinhoyi University of Technology, Institute of Lifelong Learning and Development Studies, Chinhoyi, Zimbabwe

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Abstract

Cultural factors significantly influence how family caregivers in Zimbabwe approach mental health care for their loved ones. These factors shape decisions about where to seek help and what kind of help to pursue. This study investigated the cultural influences on help-seeking behaviour for mental health conditions among family caregivers in Zimbabwe. A total of 48 participants were purposefully selected, including 14 family caregivers, 10 nurses, 4 indigenous healers, 5 pastors, and 5 Apostolic faith healers (Vapostori). Additionally, 10 community health workers took part in a focus group discussion. Data collection occurred both in community settings and at a local clinic, using a semi-structured interview guide developed by the researchers. Interviews were conducted in Shona, recorded, transcribed verbatim, translated into English, and analysed using a thematic approach. Findings revealed that cultural beliefs strongly influenced caregivers' decisions, with many preferring to consult indigenous or religious healers over biomedical services. A limited understanding of biomedical causes of mental illness, cultural stigma, and strong reliance on indigenous treatments were major barriers to seeking professional mental health care. The study highlights the urgent need for culturally sensitive interventions and suggests that collaboration between biomedical and indegenous/religious healers may improve help-seeking behaviours and reduce treatment delays.

Key words: cultural beliefs, help seeking, family caregivers, severe mental disorders, Zimbabwe

Introduction

Living with individuals with severe mental disorders (SMD) presents adverse challenges, both for the individuals and their caregivers. Mental illness (*chirwere chepfungwa)* in the Shona language) comprises a broad range of problems characterised by a combination of abnormal thoughts, emotions, behaviour and relationships with others (WHO, 2022). Caregivers, often face physical, emotional and financial strain as a result of the caregiving process and partly due to cultural beliefs about mental illness that may cause delays in seeking help. In some communities, mental illness is believed to be caused by supernatural forces, a belief rooted in cultural, religious, and historical perspectives that exist even today. Supernatural explanations for mental illness typically involve ideas that are not based on scientific or medical understanding, but rather on mystical, or religious beliefs. As a result, caregivers seek indigenous healing practices which are more accessible and culturally acceptable, resulting in delays in seeking formal health services.

Background

It is estimated that mental health disorders will account for the largest proportion of the global disease burden by 2030 (Yang, Fang, Chen et al.,2021; Collaborators, 2019). Family caregivers play a critical role in the care of individuals with mental disorders (Lauzier-Jobin & Houle, 2021) and in the process experience burden. Caregiver burden refers to the strain experienced by caregivers while providing care to a loved one over an extended period (Stamataki et al., 2014; Liu et al., 2020). In Africa, including Zimbabwe, caregiver burden is a significant issue that impacts the physical, psychological and social well-being of caregivers (Nkomo & Kekana, 2025; Andualem et al., 2024; Silaule, Adams and Nkosi, 2024; Ofovwe & Osasona, 2022; Mavingire, 2019; Marimbe et al., 2016). In a meta-analysis of 12 African studies, the prevalence of caregiver burden was found to be 61.73%, indicating a significant impact of caregiving on caregivers. While caregivers provide essential support, their experiences are shaped by cultural beliefs, which influence how they perceive mental illness and engage with mental health services (Ngubane, 2024; Ogunkonode et al., 2021). In many African societies, including Zimbabwean societies, mental disorders are not always viewed through a medical or psychological lens; instead, they may be attributed to spiritual, moral, or social factors (Jakarasi, 2024; Munaki, 2024; Subu et al., 2022; Daniel, Njau, Mtuya et al., 2018; Mojtabai et al., 2011; Sandlana & Mtetwa, 2008; Patel, 2007).

In contrast, Western societies tend to emphasize a biomedical model of mental health, where psychiatric disorders are recognised as medical conditions requiring professional medical intervention just like any other general illnesses (Patel et al., 2007). However, even in these contexts, cultural factors such as family dynamics, socioeconomic status, and previous experiences with the healthcare system can affect caregivers' willingness to seek help. One of the most significant cultural barriers to help-seeking in mental health care is stigma, which can be both public and self-directed (Bila & Carbonatto, 2022. Public stigma is the negative perceptions held by society about individuals with mental health issues, often leading to discrimination and exclusion (Corrigan, 2004). A systematic review investigating mental health stigma in African Countries revealed 5 themes that reinforced the presence of stigma (Faleti & Akinlotan, 2024. Societal stigma can influence family members to feel ashamed or reluctant to acknowledge their loved one's condition resulting in delays in seeking professional help and caregiver burden.

In many African cultures, indigenous healing practices are fundamental in managing mental illness. These practices can include spiritual healing, herbal remedies, and consulting community elders or religious leaders (Subu et al., 2022). Approximately 80% of Africans use

indigenous healers who offer important support and serve as primary health care providers, especially in rural or underserved areas (Okello & Musisi, 2015). However, they often lack the training and resources to address the complex medical and psychological aspects of mental illness (Patel et al., 2007). Family caregivers may initially turn to indigenous healing methods because they are more accessible or culturally acceptable, but this can delay or prevent the timely intervention of mental health professionals.

The interplay between indigenous and professional care can be complex. In some cases, caregivers combine both approaches, seeking the help of indigenous healers while also attempting to access medical treatment (Gupta et al., 2010). However, in other cases, caregivers may prioritize one form of care over the other due to cultural beliefs or perceived efficacy. In some African communities, mental illness is believed to be caused by spiritual forces, and therefore, caregivers may feel that only spiritual or religious interventions will effectively address the issue (Bila & Carbonatto, 2022; Mojtabai et al., 2011). This belief may conflict with the biomedical understanding of mental health, leading to reluctance in seeking formal medical care. A qualitative study conducted by Verity et al (2021) in Uganda revealed that there is reliance on indigenous healers and faith healers reflecting alternative belief systems and help seeking behaviour rather than medicalised care. Caregivers who view a loved one's condition as spiritually driven may hesitate to seek formal psychiatric treatment (Kemp et al., 2023). Health professionals need to respect these beliefs while explaining the benefits of mental health care.

Theoretical framework

The theories of Planned Behaviour (TPB), help seeking model (HSM) and the health belief model (HBM) were used to guide the study. The HBM focused on how individual perceptions of health threats and perceived benefits of taking action, influences their help seeking behaviour (Champion & Skinner, 2008). This model lacks constructs that address cultural influence on help seeking as evidenced by African studies that analyzed the concepts of the HBM (Ogunkorode et al., 2021; Melkama et al, 2021; Seboka et al., 2021). Many communities in Africa are rich in culture, which influences behaviour preferences.

The HSM just like the HBM focused on factors that influence the individual's decision to seek help for SMDs. The model helped to highlight both personal and contextual factors that influence caregivers to seek help, often when symptoms become overwhelming or distressing. The HSM brought to light the influence of cultural issues on preference for either informal or formal assistance by caregivers, thereby covering the gap in the HBM). The model also helped to identify community stigma associated with mental illness that discouraged formal help seeking. It is important to note that community knowledge determines individual behaviour and decisions to seek help (Nelson et al., 2021). Access to information was found to be critical in help seeking in the African context (Mehanna et al., 2021; Nelson et al., 2021; Seboka et al., 2021), a construct that is missing in the HBM. The TPB also helped the researchers gain knowledge and understanding that behaviour is influenced by attitudes, subjective norms and behaviour control. Just like the other models discussed, this model also emphasized the issues of caregiver attitudes to help seeking as being shaped by their cultural beliefs (Ajzen, 1991). The intersection of the three theories provided a multidimensional understanding of how caregivers navigate help seeking within different cultural contexts in the study and also provided a holistic understanding of help seeking decisions. The theories helped to guide the study on exploring the influence of culture on caregiver beliefs and behaviour. In many cultures, caregiving is viewed as a private family responsibility and seeing external help may be seen as unsuitable or stigmatized. The HSM and the TPB helped to understand how cultural

beliefs shape caregiving behaviour while the HBM addressed the practical and social barriers to help seeking.

However, the absence of an African model was a major weakness in this study. This is because this was part of a bigger study that had its original theoretical grounding in Western psychological and sociological models. Given the fact that this study explored how cultural factors shape help seeking among caregivers in an African context, the Ubuntu philosophy could have provided a deeper and relevant understanding that caregiving is a family issue rather than an individual responsibility. This omission may have constrained the analysis of how shared values, moral obligations and social cohesion influence help seeking decisions. Future similar research should integrate African frameworks in order to better understand the sociocultural realities of African caregivers and their help seeking behaviour.

Methods

Qualitative interviews (in-depth interviews [IDIs] and a focus group discussion [FGDs]) were undertaken between February and September 2023

Ethical considerations

Permission to conduct the study was obtained from the Ministry of Health and Child Care (MOHCC), Chinhoyi University research ethics board, the Medical Research Council of Zimbabwe (MRCZ) Reference number Ref: MRCZ/A/2981, indigenous healers' association and the City Health Department. Informed consent was obtained from all the study participants. Confidentiality was ensured by using numbers instead of real names for the participants.

Sample

A total of forty-eight purposefully selected participants comprising of fourteen caregivers, ten nurses, ten community health workers (lay health workers), four indigenous healers, five pastors and five *vapostori* healers participated in this study.

Data collection

Data collection was conducted in both the community and the local clinic. Fourteen family caregivers, ten nurses, four indigenous healers, five pastors and five Apostolic faith healers (Vapostori) participated in in-depth individual interviews whilst ten community health workers participated in a focus group discussion using a structured interview guide designed by the researchers. The interview guide was validated prior to data collection by three mental health professionals who included a Psychiatrist, Psychologist and Psychiatry nurse, who were conveniently selected for being both qualitative researchers and clinicians. This was done to ensure that the questions were culturally appropriate, clear, relevant, aligned with the research objectives and able to elicit rich data. Data collection was stopped after information saturation, when no new information was coming up.

Data analysis

Interviews were transcribed verbatim in Shona, which is the local language and transcripts reviewed by the researchers while listening to the audio recordings to ensure that the interview content was complete. Transcripts were later translated from Shona to English by the researchers, to facilitate analysis. Data were analysed using the six stages of the thematic approach (Braun & Clarke, 2006). These included familiarisation with the data, generation of initial codes, searching for themes, defining and naming the themes and production of the report. The steps were used as a flexible guiding framework which was not linear but a recursive process. The researchers moved backwards and forth between the stages. For

example, if a theme was identified early (phase five) and only to realise that it overlapped with another theme, researchers were prompted to revise the codes (stage 2). Themes were identified and cross-checked with the original data as well as the notes and memos that were compiled by the researchers during the interviews.

Results

Themes	***Sub-themes***
1. Lack of knowledge on the biomedical causes of mental illness	
2. Cultural perceptions about mental illness	1. *Ngozi* (Avenging spirits) 2. Witchcraft 3. Wealth accumulation rituals 4. Mental illness due to theft
3. Christocentric views on mental illness	1. Demonic possession 2. Divine will
4. Family dynamics on help seeking	
5. Stigma and discrimination	
6. Reliance on indigenous healing methods	

Lack of knowledge on the biological causes of mental illness

Some caregivers in religious communities, showed limited understanding of the biological and psychological aspects of mental illness. This limited knowledge led caregivers to depend only on religious explanations and practices avoiding professional care. Religious leaders admitted lacking training to recognize mental health disorders, yet, caregivers still sought their guidance on managing their loved one's symptoms. They associated mental illness with demon possession and often recommended prayer and fasting before considering professional mental health care. Indigenous healers similarly viewed mental illness as caused by supernatural phenomena, treating it with spiritual practices, rituals and herbal remedies.

Cultural perceptions about mental illness

Ngozi (Avenging spirits*)*

Caregivers and indigenous healers attributed mental illness to supernatural forces, notably "*Ngozi*" (avenging spirits), which influenced their help-seeking behaviours. Most participants, including the *Vapostori* sect, caregivers and indigenous healers, consistently reinforced this notion often referencing the indigenous proverb, "*munhu haarovi*," which means the soul of a person will never perish. This proverb is invoked in situations where mental illness is believed to be caused by a deceased person's spirit. The deceased person, often killed by the patient or family, even across multiple generations is believed to send an avenging spirit. This spirit can manifest as mental illness or mysterious deaths within the family.

Witchcraft

Some caregivers also attributed mental illness to witchcraft believing it to be from jealous or wicked family members casting an evil spirit on an individual, as some caregivers stated;

> *A family member came from Mozambique and was responsible for causing the mental illness in my child. My husband's younger brother's son is the one who left a snake-*

like bead on my son's bed. When he left that morning, my son started behaving weirdly. They were jealous of our success and decided to fix us (Caregiver 7) (C7).

Witchcraft can also come for no reason where some relatives can decide to bewitch you but without any reason or maybe they will be jealous and try to fix you through causing mental illness (C12).

This belief was supported by indigenous healers who claimed firsthand encounters with such occurrences like one participant said;

I had two family members who came with their mother. One was a varsity student and the other one was in secondary school. One of them I assisted and the other one I could not cleanse him after some jealous relatives bewitched them because they had a better life than other relatives – (indigenous healer 3) (IH3).

Additionally, members of the *Vapostori* church recognize the peril posed by witchcraft in precipitating mental illness like one of them said;

We have seen a number of people coming to us with issues of witchcraft. What we do is to pray for them and sprinkle them with holy water. The evil spirit then comes out and tells us that the person was bewitched, then we cleanse the person and give them holy stones as prayer tokens to protect the person. At times we cast the spirit and send it back to the witch (Apostolic Faith healer) (AFH 3).

Health professionals noted that despite believing in the biomedical causes of mental illness, still attributed their relative's mental illness to witchcraft. Even after receiving medical treatment, caregivers often pursued alternative non-medical treatments, such as indigenous remedies and spiritual healing like one of them expressed;

In the case of the lady I am talking about, the husband took another wife and it was believed that the elder wife cast a spell on the patient. They came with the patient to the clinic and after we gave her medication to calm her down, they insisted on going home with her as they believed the illness was due to witchcraft (Health Professional 7) (HP7).

Health professionals attributed this to the beliefs in supernatural causes of mental illness and the expected indigenous healing practices. They noted that some of this contributed to defaulting treatment and relapses. They further explained that the cultural perceptions of mental illness, intertwined with these beliefs, may explain why caregivers prefer spiritual and indigenous healing methods, as they align with their cultural views.

A church pastor (CP) who participated in the shared that if a person is killed, whether at a beer drinking place, for rituals or during a fight, the spirit of that deceased person continues to haunt the relatives of the murderer and to kill people in that family until it is appeased. Advising people to go and compensate those families of the deceased's avenging spirit "*kuripa ngozi*" was the solution and people often seek guidance from indigenous healers on the way forward. Even other church pastors who participated in the study acknowledged the existence of *Ngozi* but emphasized that specific rituals were necessary for appeasement. They noted that killing someone for wealth accumulation existed and that concealing the case was unnecessary as the spirit of the dead finally rises and demands compensation for the murder. The family has to meet those demands for their relative to recover from mental illness. They asserted that only blood or other offerings, such as cattle, could pacify the spirit of the deceased if a person was killed. According to them, churches are not equipped to effectively address issues related to *Ngozi* through prayer alone. Instead, they recommended seeking assistance from indigenous

sources, including "*madzimai"* (female *Vapostori* healers) and *"madzibaba*" (*male Vapostori* healers), who employ spiritual insights to provide guidance on dealing with such matters.

Wealth accumulation rituals

The practice of "*kupengeswa*" (causing of mental illness) is often linked to "*kuromba,"* (wealth accumulation ritual) in Shona belief. The Shona culture condemns *kuromba* for the pursuit of wealth and resultant mental illness, is typically addressed through churches and indigenous healers. Participants described ways *kuromba* can cause mental illness. A key distinction is that unlike *Ngozi* which affects the perpetrator's relatives, *kuromba*-induced mental illness can afflict even strangers, which shows that its impact extends beyond familial ties. Different narratives were presented, underscoring the significant symbolic meaning attributed to the behaviour of the mentally ill person by the perpetrator of *kuromba* rituals like participants expressed:

> *People can decide to use you (kushandisa munhu) for their rituals including having lucky which was common in the past. Once you are used for rituals, you become mentally ill while the same person who did that sacrifice will be making it in life (IH4).*
>
> *To boost a business, someone can decide to offer a person as a ransom to the rituals and that person will be mentally unstable but should stay happy because once he/she gets angry, the sales will be very low (IH 3).*
>
> *(Kushandiswa mumusha wawakaberekwa) Experiencing mental illness caused by people of your clan especially when you are staying away. They can perform simple rituals to use you for their benefit and when you consult us, we will tell you that your own clansmen are responsible for causing the mental illness, before we cleanse you of it (AFH 3).*

When mental illness is believed to be related to *kuromba*, families always consult indigenous healers and members of the *Vapostori* sects to trace its source. One case involved an innocent worker who fell victim to the conspiracies of a businessperson's rituals, and later developed mental illness, only for it to be discovered that the employer was behind it. In other cases, disputes over property, led individuals to use *kuromba* to afflict others with mental illness.

Mental illness due to theft

The fact that theft can trigger mental illness influenced help-seeking behaviours among caregivers. indigenous healers and faith healers discussed and elaborated on this phenomenon during in-depth interviews, citing cases where clients sought assistance at their shrines, attributing mental illness to black magic after theft. Though perspectives varied, participants' accounts reinforced each other like they expressed;

> *When you steal from someone and the person decides to fix you for stealing, you get mad which is one of the major causes of mental illness these days (AFH 1).*
>
> *If you steal, sometimes your stomach gets swollen or the indigenous healer can choose to sort the issue by making you go mad (IH 2).*

Indigenous healers noted that some people seek revenge on thieves by inducing mental illness ("*kupengesa munhu"*). These individuals typically seek out specialised traditional healers or indigenous apostolic sects, particularly those characterised by white robes *(nguwo chena)* or red robes (*nguwo tsvuku*), known for their ritual practices. The term "*nguwo"* refers to a garment, with "*chena*" and *"tsvuku"* signifying white and red, respectively. In some cases, indegenous healers or members of *Vapostori* sects offer individuals contemplating black magic

a choice between inducing mental illness, recovering their stolen belongings or in extreme cases cause death. However, in some cases, rituals are performed solely to punish thieves, leading to mental illness with no alternative outcome. Both indigenous healers and *Vapostori* sect members emphasized that unlike mental illnesses that may onset at a young age, anyone can be affected, even in later stages of life.

Christocentric views about mental illness and help-seeking

Pastors and Christ-centred caregivers attributed mental illness to wicked spirits, demonic possession, divine will and ancestral curses.

Demonic possession

Church leaders cited the biblical stories like the legion account to highlight how dark forces can drastically alter individuals' behaviour leading to isolation like one participant expressed:

> *These are evil spirits that have no place to rest on and they enter into someone and cause that person to be mentally ill and treatment is sought from those who exorcise demons (Pastor 3).*

Community health workers echoed Pastors' views supporting that demons can cause mental illness as one explained:

> *Mental sickness is a spiritual demon or bad spirit which is sent to someone by evil people and the only way of dealing with it is to go and consult the apostolic church members or Pastors who can assist with prayers and treatment for the mental illness to go (FGD CHW 2).*

Divine will

One caregiver believed that her husband's mental illness was God's will as a test of their faith as a family. She felt no other treatment was needed beyond fasting and praying. Like she explained;

> *This illness is from God maybe he wants to test us how much we believe and trust in him because we have always been Christians. This needs prayers and fasting and we will continue praying until he hears us and heals him (Caregiver 6).*

Family dynamics and the help seeking process for mental illness

Caregivers stated that in the Shona culture, the family plays a crucial role in seeking treatment for mental illness, with younger family members having to defer to elders. The authority to seek treatment, especially from indigenous healers, rests with elders. One caregiver shared the challenging experience of seeking support from indigenous healers without approval from blood relatives. Like other caregivers, she wished to involve indigenous healers and members of the apostolic sect but was unable to do so as the patient was not her biological child. Indigenous healers and caregivers explained that, in the African culture only blood relatives such as biological parents or close family members are permitted to seek treatment from these indigenous. One of the participants explained that cultural norms place the responsibility for seeking indigenous treatment solely on paternal and maternal relatives, a burden reflected in her words, as she shared:

> *My own challenge is that even if I want to go and consult indigenous healers on this problem, she is not my biological child. Hence, I do not have power to do that according to our culture as Shona people. Her biological mother is the one who should be doing*

that but I do not know where she is and my husband does not want to hear about going to indigenous healers (C1).

Stigma and discrimination

Participants expressed the issue of stigma as an important factor that affects help seeking, which should be dealt with among caregivers to improve help seeking like one participant voiced;

There is a lot of stigma associated with having a relative or family member with mental illness because according to our African beliefs, the person is bewitched or has bad spirits. It is embarrassing because it means there are witches or evil spirits in the family (FGD CHW 3).

Health professionals noted that mental illness is often misunderstood or underestimated and fear of judgement may stop people from seeking help. Concerns about social rejection also made caregivers hesitant to seek help, potentially isolating them further as one participant stated;

I am afraid of telling my friends about this illness. Can you imagine if my friends knew that I have a child with mental illness, ahh how will they look at me…. they will stop talking to me because they will think that there is witchcraft in my family (C4).

Nurses expressed that there was stigma associated with mental illness and believed that it was a deterrent in seeking assistance from the formal health services by caregivers like one of them articulated;

The stigma surrounding mental illness can delay individuals and families from seeking help. There is stigma associated with the illness, the one who is sick and his relatives are stigmatised by the community and this is mostly problematic to us as we tend to see these patients late. It is important to note that early intervention is often crucial for better outcomes but these patients are brought to us even after a year because the family does not want even neighbours to know that the patient has a mental illness (HP 7).

The other challenge stated by caregivers is that the community was stigmatising those with mental illness. They were no longer allowed to contribute during community meetings or family gatherings because of mental illness. This made them and their relatives with mental illness to withdraw from their social networks and at times the caregivers were forced to hide the patients when they had active symptoms.

Reliance on indigenous healing methods

Most of the caregivers viewed mental illness as caused by spiritual, ancestral, or supernatural forces, hence leading them to seeking healing from indigenous healers or faith healers rather than modern medicine.

Zvedzinza or zvemumusha (cultural or family issues or casting of evil spirits by family members), Huroyi (witchcraft)t and midzimu (ancestral spirits) cause mental illness. There is a case of a secondary school girl whom we attended to, who was cast with a spirit "mamhepo" sent by her "maiguru" (aunt) who decided to cast the spirit on the young girl who was considered as an heir to the pension of her father. Families come to us for treatment because these problems do not need a hospital (IH1).

Caregivers expressed that indigenous healing practices were often deeply rooted in their beliefs and customs and readily available hence, they felt comfortable to seek help from them.

When my child had mental illness, we went to seek assistance from the local indigenous healer because he understood the cultural causes of mental illness. He told us what had caused the mental illness and we were happy that he assisted us without any payment and he was always available and supportive when we had problems with my child (C 11).

Indigenous healers also expressed that their healing methods required family involvement which provided a sense of belonging and justification for caregivers. However, there were a few caregivers who preferred combining both traditional and modern methods of treatment. Caregivers often sought medical intervention to calm violent patients before taking them to an indigenous or faith healer. Nurses confirmed that caregivers would bring violent patients to the clinic and once calm, take them to a faith healer of indigenous healer as expressed by one of them;

In the case of the lady I am talking about, they came with the patient to the clinic and after we gave her medication to calm her down, they insisted on going home with her as they believed the illness was not normal, they wanted to take her to their Pastor for prayers (Health Professional) (HP7).

Some caregivers and indigenous healers had limited awareness on the availability of biomedical mental health services in the community, which contributed to delays in seeking help. Some of them were not aware that primary health facilities provided mental health services. Indigenous healers felt they were better equipped to deal with mental illness since it was caused by evil spirits and expressed that it was a waste of time to take the patient to the clinic

Discussion

Cultural factors have a great influence on help seeking for mental disorders among family caregivers. These include beliefs in supernatural causes of mental illness, reliance on indigenous healing methods, cultural perceptions about mental illness, Christocentric views about help seeking for mental illness, family dynamics in the help seeking process, stigma and discrimination. The influence of culture is more visible in mental illness than in any other health challenges (Kohrt & Mendenhall, 2016). The way mental illness is understood within in different communities is a key factor that influencing how caregivers seek help for their affected family members. In many African cultures mental illness is viewed as a spiritual problem rather than a medical issue. Mental illness is attributed to supernatural forces or punishment for wrong doing as noted in African and Asian contexts (Kometsi et al., 2020; Subu, Holmes, Arumugam et al., 2022). This aligns with the findings of this study which revealed that mental illness was due to supernatural forces. Such beliefs often influence caregivers to seek for help from religious and indigenous healers instead of health professionals. Relying on indigenous healers and spiritual leaders may delay help seeking from formal health services resulting in poor patient outcomes. In some cultures, mental illness may not be fully acknowledged especially when symptoms are mild. These symptoms may be seen as normal behaviour or a temporal phase which may lead to lack of urgency in seeking professional help.

Cultural perceptions about the causes of mental illness

Witchcraft

The findings of this study regarding witchcraft as a cause of mental illness align closely with those of Muchinako (2013), who asserted that in the African context, mental health issues are

intricately linked with witchcraft. In Zimbabwe, this association is particularly pronounced, as indigenous beliefs maintain that individuals can employ witchcraft for personal gain at the expense of others' well-being. It is believed that someone who is resentful of a relative's success may resort to witchcraft, causing various forms of suffering as supported by the results of this study. Gelfand (2012) highlighted the widespread belief in witchcraft among Zimbabweans, particularly within. family dynamics. Those afflicted by witchcraft often experience mental illness, leading to strained family relationships. Moreover, individuals who practice witchcraft resist cooperation with other family members, fearing exposure and retribution (Gelfand, 2012). In extreme cases, accusations can escalate into violence, with relatives resorting to wicked means to eliminate suspected perpetrators. This deeply ingrained belief system often prompts individuals to seek indigenous healing methods over biomedical interventions, as they perceive witchcraft as a spiritual affliction (Muchinako et al., 2013). Jealousy or wicked extended family members were also reported to be capable of casting an evil spell on an individual if they are progressing well in life, resulting in mental illness. Teffera and Shibre (2012) in their study that explored perceived causes of mental illness and preferred interventions in Ethiopia found that supernatural causes such as possession by evil spirits and bewitchment were common. This aligns with other authors in South Africa (Kometsi et al.,2020; Shange, Ross & Ngobe et al., 2021; Bila & Carbonatto, 2022).

Avenging spirits

In this study, both caregivers and informal health providers believed mental illness to be caused by supernatural forces, such as avenging spirits. The spirit of a deceased person believed to have been killed by the patient's relatives either for rituals or accidentally might manifest as mental illness. Some participants believed that mental illness was caused by some family members who would have killed a family member for ritual purposes either for gathering wealth or business success. The deceased's spirit was believed to return and cause mental illness in a family member, often linked to the use of wealth generation charms (*kuromba*). These charms came with specific instructions and if not followed properly, backfire causing mental illness in the user. This finding aligns with other researchers such as Muchinako et al, 2013 and Jakarasi, 2024 in Zimbabwe.

Sorcery

Some informal health providers in this study attributed mental illness to revenge after theft of property. This view was supported by Jakarasi (2024) whose study explored the persistence of mental illness healing practices in a Zimbabwean district. Sorcery was practised by individuals seeking justice for their stolen valuable items. Indigenous healers were consulted to use their powers to either make the thief return the stolen items or suffer mental illness if they refused to surrender themselves (Jakarasi, 2024; Muchinako et al., 2013).

Stigma and discrimination

Stigma and discrimination surrounding mental illness significantly influence caregivers' decisions to seek help for affected family members. In Zimbabwe, mental illness is viewed as a source of shame in some societies and the caregivers can be blamed for causing the illness (Marimbe et al., 2016). This may result in the caregivers hiding the patient from the society, thereby seeking assistance privately from indigenous healers or faith healers instead of health professionals. This happens out of fear of being seen by community members at the clinics or being judged or discriminated in the community. In this study, stigma was seen by health professionals as a deterrent in seeking professional health services by the caregivers. A study conducted by Audu et al (2011) in Nigeria demonstrated a negative attitude towards those with **m**ental illness, strengthening the evidence of stigma in that country. These findings aligned

with the results of a study by Chikomo (2011) in the same country which revealed the presence of stigma associated with mental illness, though in this study the stigma was as a result of lack of knowledge on the causes of mental illness.

Christocentric views about help seeking for mental illness

Religious beliefs influence how the Christian community approaches mental illness as reflected in the results of this study. Beliefs in the supernatural causes of mental illness often guide where individuals choose to seek help (Koening, 2009). Christians use various approaches to address mental health issues including prayer and fasting, religious counselling, exorcism and deliverance and community support and fellowship (Cornah, 2006). These are often led by religious leaders in various places of worship. Some may choose religious support instead of formal health services due to the belief that mental illness is caused by evil spirits or demons. In as much as this perspective may offer comfort and support to the caregivers, it may create some reluctance in seeking professional help (Hlongwane and Judy, 2023). Some caregivers in this study resorted to religious healing practices while others combined them with formal health services, supporting findings from previous studies. A study by Booysen et al (2016) on Muslims in Harare, found that mental illness was understood socially, medically and spiritually with causes such as spirits and stress. Treatment included medication, prayer and Quranic recitations. Though Muslims were not included in this study, their views align closely with the results of this study on Christocentric perceptions and help seeking.

Family dynamics

In many cultures, caregiving is a family issue. In Shona culture, family ties are critical in treatment decision making with younger family members expected to defer to elders. The authority to seek treatment in this study, especially from indigenous healers, is believed to rest with the elders. These findings echo research by Muchinako (2013) and Gelfand et al. (1985), who emphasized elders' key role in guiding mental health help-seeking in Zimbabwean communities.

Reliance on indigenous healing methods

Culture remains deeply rooted, influencing behaviour even in the medical contexts. This study found that despite advancement in mental illness treatment methods and conversion to Christianity many still turn to cultural practices and beliefs. They either would first seek a “indigenous explanation” regarding the origin of disease burden or would do so soon after they consulted the hospital as alluded beforehand. At the same time, the delay in seeking help resonates with the way mental health practices were carried out beforehand during the colonial era. As (Chikafa, Mangezi, & Kidia, 2024) indicated in their study on the subalternity of African mental healthcare systems, that despite formalised health care systems dealing with mental health were availed for Africans, they lacked the “spiritual component” which African systems provided. Resultantly, African caregivers resort to traditional systems for the explanation of mental illness, aligning with their cultural beliefs and delaying help seeking, a practise that persists today.

Conclusion

To effectively improve help seeking among caregivers of family members living with mental disorders and improve the outcome of mental disorders, it is critical for mental health professionals to be culturally and spiritually sensitive and work in conjunction with religious leaders and indigenous healers when appropriate. Discussions about the intersection of cultural

beliefs, spirituality and mental health can reduce barriers to care and promote a holistic approach to the management of those with severe mental disorders.

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