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Editorial

Sociocultural contexts of mental illness experience among Africans

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Akin Ojagbemi and Oye Gureje

Even though mental disorders can be found in every culture globally, the lived experience, expression of associated distress, and interpretation as evidence of deviance from acceptable norms are influenced by social and cultural context (Kirmayer, 2001). Hence, the context of mental illness experience should be a key consideration in the provision of culturally appropriate interventions. Historically, scant attention was paid to the unique sociocultural elements of mental disorders in Africa. In particular, early documentation of mental illness experience, predominantly by colonial psychiatrists, demonstrated little grasp of the social and cultural norms of the people. There were reports suggesting limited understanding of the local languages and modes of expression of distress, as well as failure to properly communicate directly with patients (Lucas & Barrett, 1995). Inferences about the experience of mental illness in Africans were thus made based on this lack of appreciation of diversity (Tooth, 1950). The studies in this issue of *Transcultural Psychiatry* reflect a growing body of work that is informed by the diversity and lived reality of contemporary African contexts.

Cultural understanding of mental illness

The article by Vorhölter (2021) in this issue presents a portrait of the first Ugandan psychiatric nurse. In a series of interviews, Rwashana Selina, who returned from her training in Britain in 1964 and worked in the main psychiatric hospital in Uganda until her retirement, reflected on colonial and early postcolonial European medical staff as somewhat "naive and helpless" due to their poor understanding of the local African culture and language and attendant inability to properly communicate with patients or distinguish between normal and abnormal behaviour. The story of Rwashana Selina also highlights the determination, professionalism, and dedication to patients' care of early African biomedical mental health practitioners who provided needed support for colonial and early postcolonial European psychiatrists.

Taking due cognizance of social and cultural diversity, including in the expression of distress, is increasingly recognized as salient to the practice of psychiatry in a globalizing world (Kirmayer & Ryder, 2016), and is reflected in the prominence that cultural diagnostic formulations have received in contemporary psychiatric classification (American Psychiatric Association, 2013; Gureje et al., 2019). Although current internationally adopted classifications of mental disorders are used across cultures and contexts globally (Gureje et al., 2019; Gureje, Lewis-Fernández, et al., 2020), there is an acknowledgement that the definitions of the disorders are mostly based on norms derived from Western Europe and North America (Lucas & Barrett, 1995). An exploration of this situation is provided in this issue by van der Zeijst, Veling, Makhathini, Mtshemla, et al. (2021), who report findings from a series of in-depth interviews and a cross-sectional descriptive study of trainee traditional healers. They found that some unusual experiences that would otherwise meet current definitions of psychopathological phenomena were either regarded as normal in the emic view of rural KwaZulu-Natal, South Africa, or even esteemed as evidence of extraordinary ability to communicate with ancestral spirits (Lee, 1969).

In another study, Osborn et al. (2021), reporting on several focus group discussions, found that the conceptualization of depression by indigenous Luo people of Kenya overlapped with the conceptual framework of the DSM-5. However, statistical modelling of the symptom network of depression assessed using both the well-known 9-item Patient Health Questionnaire (PHQ-9) and a new indigenous depression questionnaire co-developed with members of the local population showed that there were salient features of

Department of Psychiatry, University of Ibadan, Ibadan, Nigeria

Corresponding author:
Oye Gureje, Department of Psychiatry, University of Ibadan, Ibadan, Nigeria.
Email: oyegureje@gmail.com

depression that could only be identified by the indigenous tool. Such observations reinforce the view that current diagnostic criteria need to be applied across cultures and contexts with careful consideration of construct validity (Sweetland et al., 2014).

Partly due to the aforementioned differences in the understanding of what constitutes mental illness, the true burden of mental health problems in Africa is probably still unknown (Bughra et al., 2014). Nevertheless, the treatment gap for mental disorders in Africa is large, with studies suggesting that as many as 90% of those with diagnosable disorders do not receive needed care (Lora et al., 2012). The reasons for this gap include unaffordable cost of biomedical treatment, scarcity of mental health specialists, and geographically distant locations of the limited number of available treatment facilities (World Health Organization, 2013, 2018).

Culturally informed interventions

Other than limited access to service, there is evidence that observed treatment gaps may also be partly explained by low levels of help-seeking by people with mental health conditions. Social and cultural views of the people may affect their perception about the potential efficacy of existing interventions (Kirmayer 2015). Due to factors such as discordance between cultural beliefs and conventional psychiatric concepts of disease (Horne & Weinman, 1999), as well as the perception that biomedical treatments focus disproportionately on the person with the disease rather than on their social and community contexts (Bracken et al., 1995), some African patients may be dissatisfied with treatment and experience unmet expectation of full recovery with biomedical treatments for their mental health conditions (Kumar et al., 1996). Biomedical treatment for mental disorders may also be associated with greater perceived stigma in many African communities (Henderson et al., 2014). This may arise as a result of the observable side effects of medications such as those affecting walking and posture. Biomedical treatment facilities for mental health conditions may also be located away from the community as well as from facilities providing care for physical illness, thus engendering a sense of social alienation. In contrast, some treatment interventions based on African cultural concepts of disease may reduce stigma and result in better integration of persons with mental illness into community life (Akol et al., 2018). In a descriptive vignette study in this issue, Adu et al. (2021) found that religious devoutness, a key part of community life in Ghana and most of Africa, was negatively correlated with personal and perceived stigma for people with schizophrenia.

Three studies in this issue highlight other key sociocultural elements of potentially effective local African mental health interventions. In a qualitative vignette study, den Hertog et al. (2021) suggested that an effective local African intervention for depression should target both cognitive and emotional symptoms dimensions of the disorder by deploying available local support resources to bring relief, comfort, and distractions from "thinking too much." In a qualitative study comprising in-depth interviews, focus group discussions, and participant observations, Otake and Tamming (2021) reported that healing for northern Rwandan survivors of genocide and post-genocide massacres was traced to a process that included social and religious activities as well as co-operative thrift savings that connected them with other community members and allowed for a cognitive focus on the future. Through participant observation and in-depth interviews with traumatized survivors of war in northern Uganda, Williams (2021) also found that becoming part of a religious group and learning certain regimes of prayer can work toward recovery from traumatic experiences. A locally available, previously unexplored, but potentially effective intervention for psychosis was identified by van der Zeijst, Veling, Makhathini, Susser et al., (2021) in a series of in-depth interviews with trainee traditional healers. The authors report that the process of training to become a traditional healer relieves distress due to psychosis by converting distressing symptoms to highly valued tools to facilitate integration into a new and esteemed role in society as matured traditional healers.

Collaboration between traditional and biomedical providers

Approximately 60% of biomedical mental health service users in contemporary Africa will also consult traditional healers for their mental health conditions regardless of whether they are receiving effective hospital treatments. Traditional healers in Africa are revered within their communities and often have sustained relationships with their clientele and their families, thus ensuring continuity of care. They also have good grasps of the culturally appropriate approaches to communicate distress, and are thus available to quickly respond to changes in not only mental health but also the social, economic, and spiritual circumstances of their clientele (Iheanacho et al., 2018). Furthermore, African traditional healers have the appropriate skills to probe into the perceived social, psychological, and spiritual origins of the mental

health conditions, thus ensuring the most culturally acceptable treatment (Esan et al., 2019). Consequently, most users of their service perceive African traditional medicine treatment for mental health conditions as being effective. Adherence rates (Zingela et al., 2019) are thus substantially higher than the treatment retention rates for patients receiving biomedical mental healthcare (Wells et al., 2013).

Governmental policy in many African countries now affirms the desire for collaboration between traditional and biomedical mental health providers (Ethiopia Ministry of Health, 2012). Such collaboration may serve to emphasize positive aspects of both sectors. It may lead to earlier detection of mental health conditions, provision of more holistic care, better adherence to prescribed treatments, and community support for persons with mental illness and their family, as well as reduced stigma (Patel, 2016). A closer collaboration between the two sectors could also result in the development of novel, culturally sensitive, indigenous, but complementary, assessment tools and interventions for mental health conditions in Africa. A possible advantage of this collaboration would be the narrowing of the current treatment gap for mental health disorders on the continent. Regrettably, there have been few examples of successful collaborations between African traditional and biomedical models of mental health care in practice (Gureje, Apporah-Poku, et al., 2020).

Factors such as the profile of the traditional healer and structure of the practice were identified by two studies in the present issue as key elements of a potentially successful future collaboration between traditional and biomedical mental health providers. Van der Watt et al. (2021), reporting from a cross-sectional descriptive study of 118 traditional healers drawn from across Eastern and Western Cape of South Africa, found that "spiritualists," men, and traditional healers with a previous history of hospitalization for a mental health disorder were more likely to self-ascribe as having mental health expertise. As such, they were open to collaboration with biomedical providers. In a series of 14 semi-structured interviews conducted at a faith healing site in Ethiopia, Asher et al. (2021) found that faith healers who were former users of biomedical mental health services provided a partial gatekeeping role to such services by selecting which of their clients they thought would benefit. For these clients, the healers facilitated clinic attendance and anti-psychotic medication adherence. As reported by these authors, a key facilitator for ease of referral and access to biomedical mental health care was the co-location of a psychiatric outpatient clinic at the faith healing site.

Conclusion

This articles in this issue provide insight into the social and cultural contexts of mental health disorders and their potential applications for the development of culturally valid treatments in Africa. The studies used a range of qualitative and quantitative methodologies to examine the prevailing context of mental illness experience and treatment in Africa. As evident in this work, the history of African psychiatry was not entirely shaped by colonial and early postcolonial European medical practitioners but was also characterized by the willpower, dedication to patients, and professionalism of early African biomedical mental health providers. The work of these African pioneers helped produce important information about social and cultural diversity in the expression of mental distress and social disability. This has contributed to recent commendable steps taken to include cultural diagnostic formulations in DSM-5 (American Psychiatric Association 2013; Lewis-Fernandez et al., 2020) and a specific set of guidelines for considering culture in ICD-11 (Gureje et al., 2019). However, while current psychiatric taxonomies may be generally applicable globally, additional efforts to improve their construct validity for specific social cultural contexts are needed.

Studies included in the current issue demonstrate that existing measurement and diagnostic tools could be complemented by measures developed within particular cultural groups with a focus on how members of the population understand and interpret symptoms. The papers in this issue also highlight the need for formal biomedical mental health services in Africa to be more holistic, including by linking up with appropriate community structures and resources and deliberately facilitating social activities that connect patients with other members of the community. In this issue, we find that many trainee traditional healers started their training following personal experience of distressing psychotic symptoms which, nonetheless, were preferentially interpreted within society as evidence of ancestral calling to become a traditional healer. The training they underwent helped convert the distress of psychosis into highly valued experiences to facilitate integration into a new and esteemed role as traditional healers in their community.

These observations and others in the literature would suggest that traditional methods of mental health care in Africa confer certain therapeutic benefits that are understood and appreciated by patients and their families but which may not always be objectively verifiable in standard experimental conditions (Ojagbemi & Gureje, 2020; Zingela et al., 2019). These observations emphasize the important gaps in

conventional understanding of mental illnesses and their treatment in Africa. These gaps could be filled by paying closer attention to traditional and cultural norms of Africans including those relating to lay concepts of mental illness and its treatment. In particular, African traditional models of mental healthcare could be important untapped resources to complement prevailing biomedical systems.

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Akin Ojagbemi, PhD, MSc, FMCPsych, is an NIHR and Wellcome International Intermediate fellow at the WHO Collaborating Centre for Research and Training in Mental Health, Neuroscience, and Substance Abuse, Department of Psychiatry, University of Ibadan, Nigeria. He is the principal investigator of an ongoing study aimed at developing task shared psychosocial interventions on digital platforms for older peoples' depression in Nigeria. Akin also leads a multidisciplinary team with outpatient and in-patient responsibilities covering the mental health of older adults and dementia at the University College Hospital, Ibadan, Nigeria.

Oye Gureje, PhD, DSc, FRCPsych, is Professor of Psychiatry and Director, WHO Collaborating Centre for Research and Training in Mental Health, Neuroscience, and Substance Abuse, Department of Psychiatry, University of Ibadan, Nigeria. Dr Gureje conducts research in global mental health, epidemiology, mental health system strengthening and intervention studies. His current studies aim to develop task shared psychosocial interventions for general adults with psychosis or depression as well as for women with peri-natal depression in Nigeria.