

EXPLORING THE CULTURAL UNDERSTANDING OF MENTAL ILLNESS: A
STUDY IN THE OVAHERERO COMMUNITY, OPUWO URBAN AREA,
NAMIBIA

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ABSTRACT

This study aimed to identify and analyze the cultural understandings of mental illness, specifically its perceived symptoms, causes, and treatments, within the Ovaherero community in Opuwo, Kunene Region, Namibia. Grounded in a constructivist paradigm, the research employed a qualitative ethnographic design to explore participants' culturally embedded perceptions. Fifteen adult Ovaherero-speaking participants aged 18 years and older were recruited through convenience and homogeneous sampling techniques to ensure cultural relevance. Data were generated using a socio-demographic questionnaire and semi-structured interviews, and analyzed through thematic analysis, with Arthur Kleinman's explanatory model serving as the theoretical lens. The findings revealed that mental illness is perceived as an affliction interwoven with spiritual, moral, and social dimensions, often attributed to causes such as witchcraft, ancestral displeasure, and moral transgressions. Aggression, disorientation, and neglect of personal hygiene emerged as common indicators of mental illness. Perceptions also varied by age and gender, with males aged 25 to 40 seen as particularly vulnerable. Overall, the results highlight the need for culturally sensitive mental health interventions that integrate local explanatory models with biomedical approaches to better address the multifaceted nature of mental illness within the Ovaherero community.

Keywords: mental illness, Ovaherero community, cultural beliefs, thematic analysis, Kleinman's explanatory model, Namibia

DEDICATION

This thesis is dedicated to my family, whose unwavering support and encouragement have been the foundation of my academic journey. I also dedicate this work to the Ovaherero community in Opuwo, whose rich cultural heritage and insights have been integral to the realisation of this study.

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List of publications/ conference proceedings

Maundu, R.T., Gentz, S. & Bartholomew, T. *An Exploration of The Understanding of Mental Health: A Case Study of The OvaHerero Community, Opuwo Urban Area, Namibia.* [Conference Presentation] Health Africa International Conference (HAIC), March 2025, Windhoek, Namibia

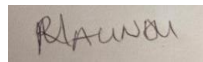
DECLARATION

I, Rijama Thessa Maundu, hereby declare that this study is my own work and is a true reflection of my research, and that this work, or any part thereof has not been submitted for a degree at any other institution.

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October 2025

Name of Student

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Date

CHAPTER ONE INTRODUCTION

1.1 Orientation to the Study

Several studies suggest that different cultures communicate, understand, and respond to psychological distress in ways deeply rooted in their unique belief systems, social norms, and collective experiences (Kirmayer & Ryder, 2016). The way individuals describe, interpret, and seek help for psychological distress is often shaped by culturally specific idioms of distress, metaphors, or explanatory models that may not align with biomedical understandings of mental illness. For example, in some communities, psychological distress manifests through somatic symptoms such as fatigue, headaches, or bodily pains, rather than through emotional or cognitive complaints (Kirmayer & Ryder, 2016). These cultural expressions can hinder the recognition of underlying mental health issues when assessed using purely Western diagnostic criteria, leading to misdiagnosis or inadequate treatment. This divergence in expression highlights the importance of culturally sensitive mental health frameworks that recognize and respect how distress is expressed within diverse cultural contexts (Subudhi, 2014).

The explanation of psychological distress is also shaped by cultural narratives that frame its causes and suitable responses (Kirmayer & Ryder, 2016). Cultural systems offer shared meanings that guide how individuals interpret their emotional suffering, attributing distress to factors ranging from interpersonal conflict and social exclusion to spiritual imbalances and supernatural forces, such as witchcraft or ancestral displeasure (Subudhi, 2014). These culturally constructed explanations influence how individuals and their families respond to mental health challenges, whether they seek help from traditional healers, faith-based interventions, or professional health services. Such cultural beliefs also determine whether individuals see psychological distress as a personal weakness, a normal reaction to life stressors, or a serious illness requiring

treatment. Therefore, understanding these culturally rooted explanations is essential for mental health practitioners aiming to build rapport and provide interventions that align with clients' worldviews.

Psychological distress, often marked by emotional suffering such as anxiety, sadness, or irritability, can be an early sign or manifestation of developing mental health issues. However, the threshold for recognizing distress as pathological varies significantly across cultures, shaped by communal norms about what constitutes acceptable emotional expression (Subudhi, 2014). As Haidet et al. (2008) highlight, recognizing and interpreting distress through a culturally sensitive perspective enables practitioners to avoid imposing culturally inappropriate diagnoses or interventions that could alienate clients.

A classic definition, as given by the anthropologist Edward Burnett Tylor (1871), as cited in Subudhi (2014), describes culture as a multifaceted entity that encompasses knowledge, beliefs, art, morals, customs, laws, and any other skills acquired by an individual as a member of society. Tylor's conceptualization emphasizes that culture is not limited to tangible artefacts or visible behaviors but also encompasses intangible aspects such as shared values, collective narratives, and community-specific ways of interpreting the world (Subudhi, 2014). Viewing culture as a complex tapestry of acquired knowledge and practices aids in recognizing its profound influence not only on daily behaviors but also on perceptions of health and illness.

In addition to Tylor's foundational perspective, Subudhi (2014) argues that human society itself can be considered a product of culture, reflecting a web of social experiences, ethics, attitudes, and ways of life passed down through socialization rather than inherited biologically. This definition positions culture as a central force in shaping

how individuals make sense of their surroundings, including how they understand and respond to concepts of well-being, suffering, and disease. For instance, what one culture regards as an acceptable emotional response or coping strategy may be viewed as problematic or pathological in another culture, depending on its communal values and social expectations. Thus, individuals' interpretations of mental health and illness emerge from a culturally embedded framework that informs their understanding of what constitutes normalcy or deviation, resilience or vulnerability.

Furthermore, mental health, as defined by the World Health Organization (WHO, 2011), is a state of well-being in which every individual recognizes their abilities, can manage the everyday stresses of life, works productively, and contributes meaningfully to their community. This definition emphasizes mental health not merely as the absence of mental illness but as a positive, holistic state of psychological and social flourishing. However, it is essential to recognize that the WHO's definition, while globally influential, often reflects Western-centric ideals that may not fully align with culturally specific notions of well-being. Therefore, mental health professionals must consider cultural variations in defining and assessing mental health, ensuring that interventions are grounded in an understanding of the cultural contexts shaping individual and collective experiences of well-being.

In contrast to definitions of mental health that focus on well-being and productivity, Keyes (2005), as cited in Subudhi (2014), describes mental illness as the presence of ongoing and distressing factors in a person's life that hinder their ability to function effectively in daily activities. This view emphasizes the disruptive nature of psychological suffering, illustrating how symptoms such as persistent sadness, anxiety, or disorganized thinking can impair an individual's capacity to sustain relationships,

fulfil social roles, or perform occupational duties. This functional impairment is a fundamental aspect of most modern interpretations of mental illness, underscoring the importance of assessing not just the presence of symptoms but also their impact on an individual's overall life functioning. Keyes' realization also reflects a shift towards understanding mental illness not as a fixed condition but as a dynamic state influenced by environmental stressors, personal vulnerabilities, and broader social factors.

Furthermore, the Oxford Dictionary of Sociology offers a more biomedical view of mental illness, defining it as "an illness characterized by the presence of mental pathology: that is, disturbances in mental functioning, similar to disturbances of bodily functioning" (Scott & Marshall, 2009, p. 462, as cited in Subudhi, 2014). This definition locates mental illness within a medical framework, drawing a direct comparison between mental and physical pathologies. It suggests that just as physical diseases result from disruptions in normal bodily processes, mental illnesses stem from disturbances in cognitive, emotional, or behavioral functioning. Such a biomedical approach has influenced diagnostic systems, such as the DSM-5, and remains predominant in clinical practice across many high-income countries. However, critics argue that this emphasis on pathology can neglect the intricate interaction between biological, psychological, and social factors that influence mental health issues, particularly in non-Western contexts where mental illness may be viewed through spiritual or communal perspectives.

Building on these definitions, Subudhi (2014) discusses two influential theoretical models for understanding mental illness: the medical model and the social model. The medical model attributes mental illness primarily to internal, biological dysfunctions such as neurochemical imbalances, genetic predispositions, or brain abnormalities. It

supports interventions, such as medication and biomedical therapies that target these internal processes. In contrast, the social model conceptualizes mental illness as behavior that deviates from societal norms, which may be labelled pathological based on cultural expectations of what constitutes acceptable conduct. This model highlights how social and environmental factors such as poverty, discrimination, or cultural taboos shape perceptions of mental illness and can exacerbate or mitigate psychological suffering. Patel et al. (2018) similarly argue for the necessity of considering sociocultural interpretations of mental illness, emphasizing that neglecting these perspectives can result in culturally insensitive care, misdiagnoses, and ineffective interventions.

Although many studies have explored cultural expressions of mental illness, research focusing on the provision of mental health services within specific cultural contexts remains limited. For example, a study by Dagsvold (2019) among the Sami ethnic group (i.e., the indigenous people of Lapland in Scandinavia) found that mental health services are somewhat less accessible primarily due to cultural and linguistic barriers between clinicians and clients. As a result, this minority may lack culturally appropriate ways to alleviate distress. More recent literature continues to emphasize the importance of culturally grounded mental health services. For instance, Kpanake et al. (2020) argue that understanding cultural beliefs about mental illness is crucial for designing interventions that are responsive to the local context in African communities.

While Orley's (1975) early study of the Baganda community in Uganda highlighted the cultural conceptualization of emotions and memory, associating the heart with emotions and the head with wisdom, subsequent work (e.g., Ventevogel, 2016) has expanded on these foundations with updated empirical evidence. Therefore, to provide

appropriate services, it is essential to understand how the client expresses mental illness within their cultural context.

Specific cultural groups and mental health have been the subject of a few studies conducted in Namibia to explore the relationship between particular cultural groups and mental health. The concept of mental illness and its representation within the cultural context of the Owambo people of Namibia is discussed (Bartholomew, 2017). In the above study, mental illness can be explained by the term *eemwengu*, which means madness in the Oshikwanyama language (Bartholomew, 2017).

This is one of the few studies conducted to explore the conceptualization of mental illness, and it has shown that it is important to consider how mental illness manifests in other cultures in Namibia. Additionally, Claudius et al. (2022) described how psychological distress (trauma) is expressed (or conveyed) within the Namibian Khoekhoe cultural community through psychological idioms of distress. These idioms relate to cultural concepts specific to that community, used to define psychological phenomena unique to it.

The empirical findings of Claudius et al. (2022) emphasise the crucial role of culturally informed practice in mental health care, especially for professionals working in diverse communities. Their research highlights how culturally specific conceptualizations of psychological distress among Namibian indigenous groups, such as the Khoekhoegowab-speaking people, provide valuable insights into local idioms of distress and explanatory models of mental illness. By understanding these cultural frameworks, mental health practitioners can communicate more effectively with clients, build trust, and adapt their interventions to align with clients' worldviews. Claudius et al. (2022) emphasise that ignoring these cultural expressions can lead to

misunderstandings, misdiagnoses, and ineffective care, ultimately damaging the therapeutic relationship and hindering treatment outcomes. Therefore, incorporating these findings into practice equips professionals with the necessary tools to deliver more empathetic and culturally sensitive services.

In addition to these insights, Bartholomew and Gentz (2019) provide empirical evidence from their study of mental health practitioners in northern Namibia, demonstrating that awareness of local conceptualizations of mental illness is essential for effective care delivery. Their research shows that practitioners who possess cultural knowledge are better equipped to identify, interpret, and address symptoms in ways that resonate with clients' beliefs and expectations. This competence allows them to bridge gaps between Western psychiatric models and local explanatory frameworks, fostering a more collaborative approach to treatment. Bartholomew and Gentz (2019) found that when healthcare providers understand culturally rooted interpretations of mental illness, such as beliefs in witchcraft or ancestral displeasure, they can anticipate clients' concerns, clarify misconceptions, and incorporate culturally acceptable interventions, thereby increasing engagement and adherence to care plans.

Specifically regarding Namibian mental health providers, Bartholomew and Gentz (2019) stress the importance for practitioners working with Owambo Namibians to develop cultural competence. Their study shows that many Owambo people understand mental illness through both traditional and modern views, often mixing biomedical explanations with spiritual or social ideas. Practitioners said that recognizing and respecting these views helped create more open conversations, lowered resistance to treatment, and improved the therapeutic relationship.

Understanding mental health within various Namibian cultural contexts necessitates an exploration of how individuals interpret and attribute meaning to mental illness. Cultural beliefs significantly shape how mental health is understood, experienced, and expressed. For practitioners and researchers, it is essential to first grasp these culturally-rooted perceptions before considering appropriate interventions. Although service provision is not the central focus of this study, acknowledging these cultural understandings is critical as they indirectly inform how mental health services may be conceptualized and approached in culturally sensitive ways

There is limited knowledge regarding the expressions, interpretations, and interventions associated with mental illness in indigenous communities. Local understandings are often overlooked, with standard biomedical and psychosocial approaches prioritized instead. To address this gap, this study applied Arthur Kleinman's explanatory model to examine specifically the expressions and understandings of mental illness, not general mental health, within the Ovaherero community of Opuwo. By focusing on mental illness, the research aimed to clarify community-specific perceptions of symptoms, causes, and culturally relevant treatments, ensuring the findings contribute to interventions that are both culturally informed and contextually appropriate.

1.2 Statement of the Problem

Mental health practitioners in Namibia frequently engage with clients from diverse cultural backgrounds. Understanding how culture influences clients' expressions of psychological distress is crucial, as it can guide the development of culturally appropriate interventions. Recognizing culture as a context-dependent variable can

help mental health professionals grasp individual experiences of psychological distress (Claudius et al., 2022). While research on cultural explanations and understanding of mental health has been conducted (Kirmayer & Ryder, 2016), these studies are predominantly Euro-centric, with samples, approaches, and researchers from European and Western countries (Claudius et al., 2022). The findings of these studies may not always be applicable to Namibia, particularly the Ovaherero community, highlighting the need for more culturally specific research.

Previous research has explored expressions of psychological distress and cultural conceptions of mental illness in the Khoekhoe and Owambo communities. However, there is a significant gap in our understanding of mental illness within the Ovaherero community. This study aims to fill this gap, exploring how the Ovaherero community interprets and responds to mental illness. Our study specifically investigates the cultural understandings, beliefs about causes, and treatment practices related to mental illness among the Ovaherero community in Opuwo Urban, Kunene Region. By focusing on mental illness rather than general mental health, this study aims to provide insights that can guide culturally appropriate interventions and enhance mental health care delivery for the Ovaherero people, potentially improving overall mental health outcomes within the community. Furthermore, the findings may have legal and policy significance by informing national mental health policies to be more inclusive of indigenous cultural beliefs and practices. This is particularly relevant in ensuring that Namibia's mental health legislation and strategic frameworks recognize and integrate traditional understandings of mental illness, thereby promoting culturally sensitive service delivery. The study also aligns with Namibia's commitments to international human rights obligations, emphasizing the right to culturally appropriate healthcare for indigenous communities. For the Ovaherero community, this research offers an

opportunity to have their cultural perspectives acknowledged in mental health discourse, which can foster the development of more accessible and respectful mental health interventions tailored to their specific cultural context.

1.3 Research Objectives

The aim of this study was to identify the cultural understandings of mental illness within the Ovaherero community. The study pursued the following specific objectives:

- To explore cultural beliefs about the symptoms and causes of mental illness
- To identify cultural interventions for mental illness

1.4 Significance of the Study

Recent research findings have revealed a pressing issue in Namibia—a significant portion of its citizens are displaying signs and symptoms of mental health diseases, with a prevalence rate estimated to be above 25% (Kafula et al., 2015). While there is still a need for more comprehensive national data, these statistics underscore the urgent need to prioritize mental illness as a public health crisis in Namibia. This urgency calls for the development of culturally sensitive and relevant treatment interventions that can address the specific needs of different groups within the country. The knowledge gained from this study could be instrumental in helping mental health professionals design interventions that are culturally and theoretically appealing and acceptable to the Ovaherero people, taking into account their cultural beliefs and cognitive representations of mental disorder. Understanding the local cultural meaning systems can significantly enhance the relevance, acceptance, and success of mental health services for Ovaherero clients provided by practitioners.

1.5 Limitations of the Study

According to recent research findings, a substantial proportion of citizens of Namibia exhibit signs and symptoms that are characteristic of mental health diseases, and it is estimated that the prevalence rate is above 25 per cent (Kafula et al., 2015). Despite the fact that there is still insufficient data on a precise national scale, these statistics highlight the acute need to revise mental illness as a priority public health problem in Namibia. It is thus essential to develop culturally sensitive and relevant treatment interventions that cater to the specific needs of different groups of people in the country. The knowledge gained in the course of this study could help mental health professionals develop interventions that are culturally and theoretically appealing and acceptable to the Ovaherero people with regard to the cultural beliefs and cognitive representations of mental disorder. Understanding local cultural meaning systems can also enhance the relevance, acceptance, and success of mental health services for Ovaherero clients provided by practitioners.

1.6 Delimitations of the Study

The researchers confined the study to the Ovaherero community in Opuwo, Namibia. This geographical area was chosen to cover the cultural setting in which the Ovaherero people lived and relied upon, which might be vastly different in terms of beliefs and practices related to mental illness compared to those of other ethnic groups in Namibia. The study directly analysed cultural beliefs specific to the symptoms, causes, and interventions of the mental illness in this community, strictly avoiding other cultural or ethnic groups to have a clear and detailed idea of the Ovaherero experience. Moreover, this research study employed a qualitative approach, and the qualitative process of gathering information was conducted through interviews, which extracted more detailed information about the community's perception of mental illness. The study was not aimed at generalising its findings to the rest of the people in Opuwo or similar areas,

given that it aimed to explore a mental illness in a specific cultural context in a very detailed way.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

Mental health and illness are important cultural determinants of mental health in any given society. Cultural lenses filter behavior in terms of categories, identify symptoms, and influence the interpretation of health or sickness (Karthick & Barwa, 2017). In this section, the points addressed include traditional belief systems in Africa, culturally congruent mental health interventions, etic and emic views on language and mental health expression, cultural competence aspects of mental health care, the constraints to mental health care, equity, and cultural aspects of meaning making as regards the implications of mental health and illness. More so, relevant studies have been carried out and the theoretical background of explanatory model that Arthur Kleinman provides has been described and synthesized according to the requirements in terms to provide a background, which can be used to interpret study results as well as defining the words and postulating some relations between the concepts, which is under consideration.

2.2 Cultural Dimensions in the Interpretation of Mental Health and Illness

Culture represents the shared patterns of behavior, values, and beliefs that characterize a society and guide how its members interpret and respond to life events, including illness. As Ogundare (2019) asserts, understanding cultural elements is crucial to appreciating how communities perceive and manage mental health and illness, since culture provides the framework through which individuals assign meaning to distress, identify symptoms, and seek help.

Karthick and Barwa (2017) define culture as a set of norms, values, and beliefs that regulate human behaviors and establish foundations for social cohesion and collective identity. Empirical studies have repeatedly shown that these cultural frameworks generate expectations about normal and deviant behavior, influencing when and how

mental illness is recognized (Ogundare, 2019). Swartz (1998) highlights that, according to the World Health Organization, mental health is defined as a state of well-being, while mental illness involves significant distress or impairment—yet this dichotomy is often grounded in Western biomedical perspectives, which may fail to resonate with many non-Western cultural groups.

In his influential analysis, Kleinman (1980) introduced the Explanatory Model, arguing that people develop culturally constructed models to interpret illness, identify causes, and select interventions. Numerous empirical studies have validated this framework across cultures. For example, Kohrt et al. (2020) found that among the Tamang of Nepal, local perceptions of mental illness were inseparably connected with spiritual beliefs and social standards. Using ethnographic fieldwork and structured surveys, they showed how mental illness was understood in terms of spiritual imbalance or breaches of social obligations, not biomedical dysfunction. This study highlighted the importance of culturally informed interventions, as discrepancies between local beliefs and mental health services hindered help-seeking and adherence to treatment.

Research by Hwang et al. (2019) on Asian American immigrants in the United States similarly demonstrates the power of culture in shaping mental health perceptions and behaviors. Through a cross-sectional survey of 250 participants, they found that cultural stigma and beliefs about mental illness significantly discouraged individuals from seeking professional care, pushing many to rely on traditional or familial healing practices. This empirical evidence reveals how perceptions of mental illness as a source of shame or moral failing can lead to avoidance of formal services, even in contexts where such services are available.

Sorsdahl et al. (2010) provide further empirical support from South Africa, where they observed that mental illness is often attributed to witchcraft or ancestral displeasure. This cultural explanation steers individuals away from biomedical services and toward traditional healers, who are seen as experts in addressing spiritual causes of illness. Their findings highlight the social function of cultural beliefs in maintaining moral order, as accusations of witchcraft often reflect underlying conflicts within families or communities. Mufunda et al. (2021) echo these findings in Southern Africa, documenting that sudden behavioural changes frequently lead to witchcraft accusations, reinforcing the view of mental illness as a breach of social or moral codes.

Asimwe et al. (2023) add to this empirical evidence by examining mental health perceptions in Ugandan communities. Their study revealed that mental disturbances are often viewed as punishment for disrespecting cultural deities or ancestral traditions. Such beliefs discourage individuals from seeking biomedical care and instead promote reliance on spiritual or ritual-based interventions. These observations support Kleinman's assertion that explanatory models are socially constructed and dynamic, evolving in response to cultural and religious influences.

Language also emerges as a critical empirical theme in understanding cultural interpretations of mental illness. Harasym et al. (2022) highlight how idioms of distress—unique, culturally bound phrases expressing suffering—shape how individuals and communities communicate mental distress. They show that idioms such as “feeling empty” or “carrying a heavy heart” are powerful vehicles for expressing complex emotions, providing shared narratives of distress that transcend clinical terminology. Orley's (1975) work with the Baganda similarly demonstrated how

cultural metaphors, such as viewing the heart as the source of emotion and memory, frame experiences of mental illness in culturally resonant terms.

Empirical research has also demonstrated how gendered cultural expectations contribute to mental illness perceptions. Kheswa and Makofane (2019) found that young African men are at elevated risk for mental health challenges due to societal expectations of stoicism and financial provision. Their qualitative research showed that men's reluctance to seek help is reinforced by cultural norms that equate vulnerability with weakness, increasing the risk of untreated distress. This empirical evidence aligns with broader studies indicating that gendered expectations shape not only individual experiences but also collective attitudes toward mental illness.

Stigma, another empirically supported dimension, profoundly influences mental health perceptions and responses across cultures. Nxumalo and Mchunu (2017) documented in their South African study that families often hide relatives with mental illness to avoid community ridicule. Their interviews revealed how beliefs associating mental illness with curses or spiritual contamination lead to social exclusion and delayed care. Goffman's (1963) theory of stigma, although conceptual, has been substantiated by such empirical findings, illustrating how labelling and social rejection of those with mental illness maintain cultural and social boundaries.

Broader systemic and historical factors also shape cultural interpretations of mental illness. Claudius et al. (2022) argue that Namibia's colonial and apartheid legacies have contributed to persistent mistrust of Western health interventions, limiting engagement with professional services. Their empirical analysis highlights how cultural identities, shaped by historical oppression, continue to influence mental health perceptions, reinforcing reliance on traditional healing systems. Cenat et al. (2024) and Jimenez et

al. (2022) expand on this by showing that structural racism and systemic inequalities intersect with cultural beliefs, creating compounded barriers to accessing mental health care in marginalized communities globally.

Mukolo et al. (2020) provide additional empirical support for the evolving nature of explanatory models. Their research in multiple African communities demonstrated that cultural beliefs about mental illness are increasingly incorporating psychosocial explanations, including stress, trauma, and social isolation. This shift suggests a growing openness to integrating biomedical concepts with traditional understandings, provided interventions respect and build upon local cultural frameworks.

Empirical evidence has also highlighted the impact of treatment credibility on perceived efficacy. Bartholomew (2018) showed in his Namibian research that belief in a treatment's cultural legitimacy directly influences whether individuals consider it effective. Without alignment between explanatory models and interventions, even clinically proven treatments are likely to be rejected. Keikelame and Swartz (2019) similarly found in South Africa that blending Christian faith practices with traditional rituals enhances the credibility of mental health interventions among communities that interpret mental illness through spiritual lenses.

Overall, these empirical studies converge on the conclusion that mental illness perceptions, symptom recognition, help-seeking behaviors, and treatment choices are fundamentally shaped by cultural beliefs and explanatory models. They support Kleinman's assertion that mental health care must engage with locally constructed meanings of illness to be effective. Interventions that fail to acknowledge cultural beliefs risk being dismissed as irrelevant or inappropriate, undermining treatment engagement and outcomes.

This body of empirical literature demonstrates the universality of culture's influence while also highlighting its variability across contexts. From the Tamang in Nepal (Kohrt et al., 2020), to Asian American immigrants in the U.S. (Hwang et al., 2019), to communities across Africa (Sorsdahl et al., 2010; Asimwe et al., 2023; Nxumalo & Mchunu, 2017), cultural frameworks dictate how mental illness is understood and managed. These findings collectively emphasise the critical need for culturally competent mental health care that respects and incorporates cultural knowledge systems, local languages, idioms of distress, gender norms, and historical legacies.

As Patel et al. (2018) conclude, mental health interventions designed without cultural sensitivity risk ineffectiveness and can even exacerbate stigma or mistrust. Empirically grounded understanding of cultural dimensions is thus essential for practitioners, researchers, and policymakers seeking to advance mental health equity in multicultural societies.

2.3 The Role of Culture in Shaping Mental Illness Perceptions

Culture plays a critical role in shaping how individuals perceive, express, and respond to mental illness. Every person is embedded within a cultural context that influences their behaviors, coping strategies, and patterns of help-seeking. These cultural frameworks dictate what is considered normal or deviant behavior, how symptoms of mental illness are recognized and described, and what interventions are regarded as appropriate or effective (Ogundare, 2019). Cultural norms, therefore, do not merely frame individual perceptions but profoundly shape communal interpretations of mental health, often determining whether individuals receive support or face stigma.

Kirmayer and Ryder (2016) emphasise that cultural beliefs influence how emotions and mental states are interpreted. For example, anhedonia—a key symptom of depression—

may be experienced and communicated differently across cultures depending on prevailing norms regarding sadness, pleasure, and emotional restraint. In some cultures, the inability to participate in communal activities or fulfil family obligations may be a primary indicator of distress. In contrast, in others, personal sadness or loss of interest in individual hobbies may be emphasized (Kirmayer & Ryder, 2016). These differences have significant implications for diagnosis, as symptoms that fit standardized criteria in one culture may be overlooked or reinterpreted in another.

Empirical studies have validated the importance of understanding cultural frameworks to improve mental health interventions. Kohrt et al. (2020) investigated perceptions of mental illness among the Tamang people of Nepal using a mixed-methods approach that combined ethnographic fieldwork and structured surveys. They found that local understandings of mental illness were inseparably connected to spiritual attitudes and social norms, including beliefs about karma and ancestral displeasure. Mental illness was interpreted not only as a personal affliction but also as a reflection of social imbalance, requiring community-based or spiritual interventions. Kohrt et al.'s (2020) findings underscore the need for interventions to align with local cultural interpretations to be effective, especially in non-Western settings.

Similarly, Hwang et al. (2019) conducted a cross-sectional survey of 250 Asian American immigrants in the United States to explore how cultural stigma and beliefs affect help-seeking behavior. Their study revealed that cultural stigma and concerns about family honor were significant barriers to accessing professional mental health care. Many participants described avoiding therapy or psychiatric treatment because they feared bringing shame upon their families. Instead, they relied on traditional remedies or spiritual practices. These findings emphasise that interventions must

address stigma within culturally specific frameworks to increase utilization of mental health services in diverse populations.

Research from African contexts has produced consistent findings. Sorsdahl et al. (2010) studied explanatory models of mental illness among traditional healers in South Africa, showing that many mental health problems were attributed to supernatural forces such as witchcraft or ancestral punishment. These beliefs led individuals to consult traditional healers rather than professional mental health providers, demonstrating how cultural perceptions of aetiology directly influence help-seeking pathways. Similarly, Mufunda et al. (2021) reported that in Southern Africa, accusations of witchcraft often arise when sudden or unexplained behavioural changes occur, leading to the interpretation of mental illness as a social or moral issue rather than a medical condition. Such interpretations can delay professional treatment, increase social isolation, and perpetuate stigma.

Asiimwe et al. (2023) provide further empirical evidence from Uganda, where mental illness is frequently understood as resulting from disrespect toward ancestral spirits or neglect of traditional customs. Their study found that families and communities often perceive mental illness as a form of punishment for moral or spiritual transgressions. Consequently, families are more likely to seek help from spiritual leaders or traditional healers than from mental health professionals. These findings illustrate how cultural perceptions not only shape individual behavior but also create community-wide patterns of response to mental health issues.

The importance of cultural beliefs in shaping mental illness perceptions is also evident in research by Kheswa and Makofane (2019), who explored gendered expectations and mental health among African men. Their qualitative interviews revealed that societal

norms requiring men to be stoic providers increased their vulnerability to mental health problems while discouraging them from seeking help. These findings highlight the intersection of culture and gender, demonstrating that cultural expectations can exacerbate distress by stigmatizing help-seeking behavior, particularly among men.

Language is another dimension of culture that shapes perceptions of mental illness. Harasym et al. (2022) discuss how idioms of distress—culturally specific expressions for suffering—offer insights into local interpretations of mental health. Their analysis across diverse cultural settings revealed that idioms such as “feeling empty,” “carrying a heavy heart,” or “thinking too much” convey distress in ways that reflect cultural understandings of emotion, morality, and social relationships. Harasym et al. argue that recognizing these idioms in clinical encounters is essential for culturally competent care, as they provide clues about the meaning individuals attach to their symptoms and the kinds of interventions they might find acceptable.

Kohrt et al. (2016) also emphasise the importance of idioms in understanding cultural models of mental health. Their study in Nepal revealed that idioms such as “soul loss” or “heart-mind imbalance” conveyed complex meanings that encompassed the spiritual, social, and emotional dimensions of distress. Ignoring these idioms in mental health services risked misdiagnosis and reduced the likelihood of treatment adherence, further underscoring the need for culturally sensitive diagnostic frameworks.

Empirical research also demonstrates that stigma, a social process deeply rooted in cultural beliefs, profoundly affects mental health perceptions and outcomes. Nxumalo and Mchunu (2017) conducted interviews in KwaZulu-Natal, South Africa, revealing that families frequently conceal mentally ill relatives out of fear of social ridicule and shame. These families experienced feelings of isolation, blame, and social exclusion,

reinforcing cycles of stigma that prevent early intervention and effective care. Such findings are consistent with Goffman's (1963) theory of stigma as a culturally mediated process of labelling and exclusion.

Structural and historical factors compound these cultural dynamics. Claudius et al. (2022) argue that Namibia's colonial and apartheid histories have produced deep-seated mistrust of Western institutions, including medical services. Their empirical analysis highlights how historical trauma and systemic inequalities shape cultural perceptions of mental illness, encouraging reliance on traditional healing methods while deterring engagement with formal mental health systems. These findings show how culture cannot be understood in isolation but must be contextualized within broader socio-political histories.

Cenat et al. (2024) and Jimenez et al. (2022) add empirical support from studies on structural racism, which intersect with cultural beliefs to limit mental health access for marginalized communities globally. Cenat et al.'s systematic review found that racism and discrimination reinforce cultural stigma, reduce trust in health systems, and contribute to disparities in mental health service utilization. Jimenez et al. (2022) documented how these dynamics result in poorer mental health outcomes for communities of colour in the United States, as fear of discrimination discourages individuals from seeking care.

In their multi-country analysis, Patel et al. (2018) emphasise the importance of integrating cultural meaning systems into mental health services to enhance effectiveness and reduce disparities. Their findings across low- and middle-income countries reveal that culturally insensitive interventions often fail because they do not resonate with local beliefs about illness, healing, and social roles. Patel et al. argue that

culturally competent care, grounded in an understanding of local explanatory models, is essential to achieving equitable mental health outcomes.

Kleinman's (1980) Explanatory Model provides a unifying framework for these empirical findings, emphasizing that individuals and communities create culturally specific models that define what illness is, what causes it, and how it should be treated. These models are socially constructed, dynamic, and influenced by shifting cultural, religious, and social factors. Studies such as those by Kohrt et al. (2020), Hwang et al. (2019), and Sorsdahl et al. (2010) empirically demonstrate Kleinman's theory in diverse contexts, illustrating how explanatory models influence both symptom recognition and pathways to care.

Bartholomew (2018) extends this empirical understanding through research in Namibia, revealing that cultural credibility determines treatment acceptance. His findings show that even interventions proven effective in clinical trials are often rejected if they do not align with local explanatory models. Keikelame and Swartz (2019) similarly report that in South Africa, blending Christian faith practices with traditional healing increases the perceived legitimacy of interventions, enhancing engagement and outcomes.

Empirical studies also highlight the adaptability of cultural explanatory models. Mukolo et al. (2020) found that in several African communities, beliefs about mental illness are shifting to include psychosocial factors such as trauma, poverty, and social disconnection. Their study suggests that cultural models are not static but evolve in response to social changes, creating opportunities for interventions that bridge traditional and biomedical perspectives.

The convergence of these empirical findings underscores that culture shapes mental illness perceptions not as a static backdrop but as a dynamic, evolving system of meanings and practices. Cultural norms, language, idioms, gender roles, and historical legacies collectively define how mental illness is experienced, diagnosed, and treated across societies. Effective mental health care requires recognizing these cultural dimensions and integrating them into service delivery, policy, and training.

As Patel et al. (2018) argue, culturally competent care must go beyond translation or token gestures; it must involve deep engagement with cultural narratives, community knowledge systems, and the socio-political contexts that shape mental health experiences. Without this commitment, interventions risk misunderstanding local needs, exacerbating stigma, and perpetuating disparities in mental health outcomes.

2.3.1 Cultural conceptualizations of mental illness

Explaining mental health and mental illness in various cultures can be achieved by considering the causes of mental health and illness (causal explanations) within that given culture, as perceived by individuals. Causal explanations consist of a system of assumptions that people hold as to understanding the causes of a particular phenomenon (Mirza et al., 2019). These explanatory efforts can help one understand their surroundings by observing things in terms of specific causes, either internal — such as an attribute of oneself or an action — or external, whether it is situational forces or external circumstances (Mirza et al., 2019). Additionally, Elliot et al. (2013) referenced the attribution theory, which states that the most helpful reasoning about unfavourable events involves attributing them to factors that one cannot control. Pinning the notions on outer reasons, individuals are likely to maintain a positive self-image and decrease a sense of guilt or failure (Elliot et al., 2013). This protective

mechanism can help individuals in managing adverse consequences by maintaining their self-esteem and building psychological resilience (Elliot et al., 2013).

Although mental health conditions may emerge in societies of all cultures, their explanation, the consequences they pose to affected individuals, and how societies react to those affected may also differ significantly according to the type of culture (Mirza et al., 2019). Such is proven by the study carried out by Elliot et al. (2013) on inpatients suffering various mental diseases in the United States of America. To examine the reasons why persons hospitalized with mental illness developed it, they carried out their research using a qualitative in-depth interview. The researchers also used these interviews to collect personal accounts on the possible causes of their mental health conditions in detail. Such a method led to a nuanced understanding of how patients perceive the causes of their diseases, with a variety of reasons presented, ranging from their genetic makeup and neurochemical pathways to life stresses and social interactions. This research had shown that when facing the acute episodes of mental illness, regardless of the clinical diagnosis, these individuals are characterized by a strong tendency to explain their condition mainly by the difficult life experiences and definite physical illnesses so, as a result, they attribute the role of causes of mental illnesses to biological, psychological as well as social forces.

In addition, a third research, conducted by Hall (2014) in the USA, encompassed cross-examination of how ethnicity interacted with perceptions of mental illness in a group of school teachers, the research sample of which totaled 513 representatives: 325 of the subjects belonging to the White group and 182 belonging to the Black one. Through their analysis, it was shown that African American and white American/ Caucasian

American individuals had significant differences in the subjective conceptualization of mental illness. As it is indicated by Hall (2014), the responses of white participants were closer to the opinions that are common among mental health professionals, and those of black or African American participants were more representative of a more conservative way of seeing mental illness. In particular, there was a greater probability among African American teachers than in White American teachers to believe in a set of ideas that presuppose that people with mental illnesses have observable deviations in appearance and behavior in contrast to individuals who have no such problems (Hall, 2014). This paper highlights the value of cultural and ethnic backgrounds in shaping opinions towards mental illness, which emphasizes the need to be aware of such forces in other communities, such as the Ovaherero. Through the identification of these cultural disparities, studies such as Hall's (2014) and the researcher's work could, through their findings, educate more effective responses to the task of mental health care with an eye towards the specifics of cultural diversity.

Research generally indicates that individuals from Western cultures predominantly hold biological and psychological perspectives regarding mental illness. In contrast, those from non-Western cultures are more likely to adopt sociological and theological explanations (Pang et al., 2018). In addition, Pang et al. (2018) conducted research examining the causal beliefs about mental illness among certain ethnic groups, such as the Chinese, Malay, Indian, and others, within a nationally representative sample from Singapore, a Southeast Asian country. By comparing these groups on their beliefs of the causes of five mental disorders, namely depression, schizophrenia, obsessive compulsive disorder, dementia and alcohol abuse, this study employed an exploratory factor analysis, yielding three factors (Pang et al., 2018). The following were the results: The first factor included everyday sociological problems such as stress, family

arguments, difficulties at work, or financial difficulties, recent death of a close friend or relative, recent traumatic event such as a severe traffic accident, and childhood problems such as being badly treated or abused, losing one or both parents when young, or coming from a broken home (Pang et al., 2018). The second factor consisted of having a weak character, and the third factor encompassed either supernatural or biological attributions of mental illness, specifically a virus or other infection, allergy, or reaction, and spirit possession (Pang et al., 2018). These results may support the notion that different cultures conceptualize and explain the aetiology of mental illnesses differently.

Complementing the studies mentioned earlier, Goyal et al. (2023) investigated the causal explanations of perinatal depression among women in sub-Saharan Africa. The study found that these women attributed depressive symptoms to traumatic experiences, relationship issues such as polygamy, lack of support, neglect, and infidelity, as well as financial hardships. In addition, being single, divorced, separated, unemployed, lacking support, relationship issues, abuse, unwanted or unplanned pregnancies, food insecurity, and cultural factors (such as not being able to follow postnatal traditions, not being able to rest after giving birth and being attacked by "bad spirits") are risk factors linked to the development of perinatal depression (PD) in sub-Saharan Africa (Goyal et al., 2023).

2.4 Traditional belief systems in Africa

Mental illnesses may be linked to bewitchment or the influence of ancestors in many traditional African belief systems, according to Sorsdahl et al. (2010). For example, in Uganda, discussions about mental illness often reflect a firm belief that it is caused by supernatural forces, including witchcraft, possession by evil spirits, or punishment for disrespecting cultural or ancestral gods (Asiimwe et al., 2023). Adding to this, Sorsdahl

et al. (2010) carried out a study in Mpumalanga, South Africa, where they enquired about the views traditional healers held about the causes of mental illness. According to this study, the traditional healers asserted that mental illness could arise from various causes, with witchcraft and possession by evil spirits being the most prevalent (56%). Witches were believed to possess the ability to harness their malevolent powers and manipulate natural forces to harm others (Sorsdahl et al., 2010). The term "amafufunyana" was specifically used by Zulu-speaking respondents to describe mental illness attributed to witchcraft (Sorsdahl et al., 2010).

Furthermore, "amafufunyana" is considered a severe disorder frequently attributed to witchcraft (Sorsdahl et al., 2010). However, some individuals believed that this illness resulted from untreated causal factors such as family problems, substance abuse, and poverty, which progressively worsened (Sorsdahl et al., 2010). Another belief posited that ancestors, when calling an individual to become a traditional healer, inflict a mental disorder on that person as an antecedent to the period of spirit possession, known as "ukuthwasa" (Sorsdahl et al., 2010).

Within the Namibian context, there is minimal research carried out to explore specific cultural conceptualizations of mental health. Although Namibia is home to diverse cultural groups, existing literature indicates that causal explanations of mental illness in Namibia often mirror those reported in Uganda and South Africa, where supernatural attributions such as witchcraft, ancestral displeasure, and spiritual possession are standard explanatory models (Patel et al., 2018). These similarities suggest shared cultural beliefs across many African contexts regarding the origins of mental illness. This pattern of attributing unexplained illness to supernatural causes is evident in the Caprivi (Zambezi) region of Namibia, where Thomas (2007) found that witchcraft was

commonly regarded as a plausible explanation for physical ailments such as HIV/AIDS, highlighting how cultural beliefs shape understandings of illness more broadly. Furthermore, although individual cases of witchcraft in the Caprivi region are not openly publicized, people discuss them openly during focus groups and interviews (Thomas, 2007). Beliefs in witchcraft were prevalent not only in rural areas but also in the region's only town, Katima Mulilo and these beliefs were common among individuals working for government ministries and NGOs (Thomas, 2007). In addition, a report by Vranckx (1999) focused on the prevalence of schizophrenia in the northwestern Kunene region of Namibia. The goal of the research team was to find OvaHimba group members in Kaokoland who were living in a traditional, non-Westernized environment and showed signs of schizophrenia (Vranckx, 1999). The results of this study mentioned that religious beliefs based on animism were common among the OvaHimba people (Vranckx, 1999). Through rituals that promote "hearing voices" and "seeing people who passed away long ago," these belief systems foster the maintenance of close relationships with deceased ancestors, which makes some symptoms of schizophrenia more consistent with everyday life (Vranckx, 1999).

According to this report, there is a common understanding amongst this community that supernatural forces are the source of all illnesses and unfortunate events (Vranckx, 1999). The manifestation of a curse, the loss of ancestral protection, the existence of malevolent spirits, witchcraft and sorcery are some examples of these supernatural forces (Vranckx, 1999). Overindulging in alcohol (and in some instances, marijuana) is stated as a contributing factor to mental illness, but this tendency itself might be an evil power at work (Vranckx, 1999). Furthermore, this conviction is reinforced when a friend or relative experiences a change in their health to the point where it appears as

though a weird, foreign mind is inhabiting their recognizable body, and the best illustration of a supernatural influence is mental illnesses (Vranckx, 1999).

Furthermore, Bartholomew (2017) conducted a study focusing on the Owambo community, located in northern Namibia, to explore their perceptions of mental health. The study identified mental illness, known as *eemwengu* in the *Oshikwanyama* language, which is translated to madness. The study also illustrated a connection between cultural beliefs, madness, and distress (Bartholomew, 2017). These examples from various African contexts, including Namibia, highlight the deeply rooted cultural beliefs linking illness (including mental illness) to supernatural forces such as witchcraft, spirit possession, and ancestral intervention. Such beliefs underscore the need for further investigation into how the Ovaherero community perceives mental illness.

2.5 Culturally Congruent Mental Health Interventions

Developing effective mental health interventions requires a nuanced understanding of the cultural contexts in which psychological distress is experienced, expressed, and treated. Empirical research shows that treatment acceptability and efficacy are deeply rooted in cultural beliefs, norms, and explanatory models of illness. Elliott et al. (2013) argue that mental health practitioners must recognize how patients conceptualize the nature and causes of their illness, as well as their attitudes toward different forms of treatment. Ignoring these cultural interpretations risks rendering even the most evidence-based interventions ineffective or culturally irrelevant.

Bartholomew (2018) supports this view with empirical findings from Namibia, demonstrating that belief in the legitimacy of a treatment is crucial for it to reduce distressing symptoms effectively. His research shows that the culturally constructed

meanings of illness shape the acceptability and credibility of an intervention. If a treatment is not congruent with these cultural beliefs, patients may reject it, regardless of its clinical validity. This empirical insight challenges the universality of Western psychotherapeutic and psychopharmacological models, highlighting the need for culturally adapted interventions.

Sorsdahl et al. (2010) provide further evidence from South Africa, where they found that Western mental health frameworks often overlook cultural diversity and rely on reductive assumptions about African patients. Their interviews with traditional healers and patients revealed that Western practitioners frequently misinterpret cultural idioms of distress and explanatory models, reinforcing stereotypes and deepening mistrust. This dynamic not only perpetuates health disparities but also undermines the therapeutic alliance necessary for effective treatment. Their research highlights the limitations of imposing Western-centric models in contexts where local beliefs about mental illness include spiritual, social, and moral dimensions.

This empirical literature contradicts stereotypes that Africans inherently prefer traditional healing over biomedical interventions. Sorsdahl et al. (2010) emphasise that the preference for traditional healers often reflects a lack of access to professional mental health services rather than an inherent cultural opposition to biomedical care. Their findings reveal that, where accessible, culturally competent biomedical interventions are accepted and utilized, provided they respect local beliefs and practices. These insights underscore that accessibility and cultural relevance are intertwined factors in determining treatment pathways.

Wieland et al. (2011, as cited in Bartholomew, 2018) also document how cultures develop their conceptions of change and therapeutic practices, which may differ

markedly from Western psychological and psychiatric interventions. Their empirical work on complementary and alternative medicine (CAM) demonstrates that such practices, ranging from herbal remedies to rituals, are not merely remnants of outdated traditions but rather reflect culturally meaningful responses to the experience of suffering. These therapies offer solace, reinforce shared cultural values, and provide a sense of agency during crises, strengthening community bonds and individual resilience.

Mufunda et al. (2021) corroborate these findings with research on Southern African communities, observing that traditional healing practices are often embedded in social and spiritual frameworks that address both individual distress and communal harmony. Their ethnographic study found that treatments often include rituals designed to restore balance within families or communities, reflecting beliefs that mental illness disrupts social and spiritual equilibrium. Such practices not only aim to alleviate symptoms but also reinforce collective values, illustrating how interventions are inextricably linked to the cultural landscapes in which they occur.

Studies on Asian American populations further validate the importance of cultural congruence. Hwang et al. (2019) demonstrated that culturally tailored interventions, which integrate patients' beliefs, by incorporating spiritual discussions or involving family members, improve engagement and outcomes. Their cross-sectional research found that patients who perceived mental health providers as culturally understanding were significantly more likely to attend follow-up appointments and adhere to treatment recommendations. This finding underscores the empirical importance of aligning interventions with patients' cultural frameworks to build trust and promote effective care.

Kohrt et al. (2020) provide another example from Nepal, where their study revealed that mental health interventions designed without regard for cultural knowledge systems faced significant resistance. Their mixed-methods research demonstrated that interventions acknowledging local beliefs, such as the role of karma and spiritual pollution, enhanced participation and reduced stigma associated with mental health services. These empirical findings emphasise that culturally grounded care does not require abandoning evidence-based practices but rather adapting them to reflect local explanatory models and community values.

Harasym et al. (2022) emphasise the importance of culturally specific language in enhancing the effectiveness of interventions. Their global comparative study on idioms of distress reveals that using culturally resonant terms during therapy sessions can facilitate a shared understanding between the clinician and patient, thereby fostering therapeutic rapport. They argue that ignoring local idioms risks alienating patients or misinterpreting their experiences, leading to ineffective or harmful interventions. Idioms like “carrying a heavy heart” or “thinking too much” are not mere linguistic curiosities but essential expressions of how individuals conceptualize suffering and what forms of healing they expect.

Nxumalo and Mchunu (2017) add empirical depth with research on the stigma-related experiences of family members of people with mental illness in South Africa. Their interviews revealed that culturally informed interventions addressing family-level stigma are essential to creating supportive environments for patients. Their study shows that without culturally sensitive approaches to reducing stigma, families may conceal mental illness, delay treatment, or resort to ineffective remedies, perpetuating cycles of distress. Culturally congruent psychoeducation campaigns, which integrate community

beliefs with biomedical information, were found to improve family engagement and patient outcomes.

Jimenez et al. (2022) extend these insights to racially and ethnically marginalized populations in the United States. Their empirical work reveals that when interventions fail to address both cultural and systemic barriers, such as racism, language differences, and mistrust of healthcare institutions, patients are less likely to engage with services. Their findings emphasise that culturally congruent interventions must go beyond individual beliefs to address structural factors that shape mental health disparities, reinforcing the intersection of cultural and systemic considerations.

Patel et al. (2018) provide one of the most comprehensive empirical analyses on the need for culturally adapted interventions. Through their work with the Lancet Commission on Global Mental Health, they document how interventions tailored to local cultural contexts significantly improve outcomes across low- and middle-income countries. They argue that culturally congruent interventions respect patients' cultural identities and integrate traditional healing practices with biomedical care where appropriate, enhancing acceptability and effectiveness. Patel et al. conclude that culturally insensitive interventions, regardless of their clinical rigor, are likely to fail in addressing the mental health needs of diverse populations.

Empirical studies have also shown that interventions designed with community participation are more successful. Kohrt et al. (2016) demonstrated that involving local leaders, healers, and affected families in the design and delivery of mental health programs in Nepal increased trust, reduced stigma, and improved adherence to treatment plans. Their findings highlight that community engagement is not a peripheral strategy but a core component of culturally congruent care.

Bartholomew (2018) similarly found that Namibian communities responded more positively to interventions co-developed with traditional healers and local stakeholders, who helped frame mental health problems in culturally familiar terms. This partnership approach created culturally acceptable explanations for mental illness, addressed misconceptions, and increased willingness to engage with both traditional and biomedical services.

The empirical literature also illustrates how hybrid interventions, blending biomedical and traditional approaches, can enhance cultural congruence. Keikelame and Swartz (2019) observed in South Africa that mental health services incorporating pastoral counselling or traditional cleansing ceremonies alongside medical treatments were more acceptable and effective in communities with strong Christian or indigenous beliefs. These findings support the principle of complementarity, which involves acknowledging and respecting multiple explanatory models without dismissing either traditional or biomedical perspectives.

Mkhize and Nkomo (2022) further argue, based on their empirical research, that culturally congruent care involves not only understanding patients' explanatory models but also training clinicians to engage with them respectfully. Their South African study showed that mental health professionals who received cultural competence training were better able to recognize and integrate cultural beliefs into treatment plans, leading to improved therapeutic relationships and outcomes.

Cenat et al. (2024) provide additional empirical support for culturally adapted interventions, emphasizing that racism and systemic inequities must be addressed alongside cultural beliefs. Their systematic review revealed that culturally grounded interventions were more effective when they included strategies to counteract

discrimination, build community support networks, and enhance patient empowerment. This holistic approach acknowledges that culture and social structures are intertwined factors shaping mental health experiences.

As Patel et al. (2018) assert, culturally congruent interventions must be designed in collaboration with communities, integrating their explanatory models, preferred healing practices, and social realities. This process involves ongoing dialogue, flexibility, and humility on the part of mental health professionals, who must recognize the limitations of applying universalized Western models in diverse cultural contexts.

2.6 Etic and Emic Perspectives on Language and Mental Health Expression

As discussed in the sections above, the impact of culture on mental illness is profound, as language, communication styles, and social norms significantly shape how mental health issues are understood, experienced, expressed and treated. In this section, the etic and emic perspectives are presented to analyze the influence of culture on the expressions and communications of mental illness.

According to Chen (2010), the etic approach is concerned with understanding human behavior and psychological processes from a universal standpoint. It seeks to identify commonalities and general characteristics across different cultures, emphasizing universal aspects of human experience (Chen, 2010). This approach allows researchers to compare and contrast mental health phenomena across diverse cultural settings, highlighting similarities that may exist despite cultural differences.

In contrast, the emic approach focuses on understanding behaviors and psychological processes from within a specific cultural context (Chen, 2010). It emphasizes the unique aspects of a particular culture, such as its values, beliefs, and social norms, and how these elements shape the understanding and manifestation of mental health and illness

(Chen, 2010). The emic approach is essential for capturing the nuances of mental illness within a specific culture, as it delves into culturally specific interpretations and experiences that may not be apparent through an etic lens (Chen, 2010). By integrating both the etic and emic approaches, researchers can gain a more comprehensive understanding of how mental illness is represented and experienced within a culture. The etic approach provides a broader context for understanding mental health by identifying universal patterns.

In contrast, the emic approach provides in-depth insights into the unique cultural factors that influence mental health within specific communities. This dual approach is critical in cross-cultural psychology, as it ensures that the cultural specificity of mental illness is understood and respected, while also recognizing the universal aspects of human psychology (Chen, 2010). Therefore, it is essential to understand specific cultures from the emic perspective, with the etic approach in mind, to gain a deeper understanding of the representation of mental health and illness within that culture. Building on this dual approach, it is essential to explore how these theoretical frameworks manifest in the language and expressions used within different cultures, particularly in the context of personal distress.

According to Harasym et al. (2022), it is common for different cultures to use language that is specific to them when expressing certain personal distress. Examples include idioms of distress, which are expressed personal states that range from mildly stressful to extreme suffering (Harasym et al., 2022). In addition, the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (APA, 2013), describes cultural idioms of distress as methods of expressing distress that do not necessarily correspond to specific symptoms or syndromes, but instead offer shared ways for individuals to communicate

their personal or social distress. For instance, discussions about feelings like "nerves" or "depression" can encompass a diverse range of experiences of suffering without aligning with a distinct set of symptoms, syndromes, or disorders (APA, 2013). In certain situations, these can be helpful ways for people to communicate and cope with distress in a culturally and interpersonally appropriate way (Harasym et al., 2022).

Furthermore, Harasym et al. (2022) mention that within the clinical psychology field in the global north, terms such as feeling trapped or immobile are used in relation to psychological disorders such as depression and anxiety. Clients, according to psychologists in the United Kingdom, use metaphors such as immobility to express their feelings of powerlessness, doing so as a way to communicate without directly facing their overwhelming feelings (Harasym et al., 2022). This study also indicates that feelings of being trapped may be directly correlated to intergenerational trauma, increasing a sense of powerlessness or a lack of control over former trauma (Harasym et al., 2022). Women in the United States of America and Hong Kong, according to Harasym et al. (2022), used feeling trapped as a metaphor to describe their experiences of postpartum depression.

Moreover, a study by Asiimwe et al. (2023) reveals several idioms of distress among different cultural communities in Uganda and Kenya, which are passed down from one generation to the next. These idioms contain local and cultural shared interpretation of social, psychological and biological symptoms of mental illness (Asiimwe et al., 2023). Among the Kenyan Kiswahili-speaking community, the cultural idioms of *dhiki* (stress or agony), *huzuni* (sadness or grief), and *kufikiria sana* (overthinking) were used to express psychological distress, according to Asiimwe et al. (2023). These different idioms express different psychological and emotional distresses. For example, Asiimwe

et al. (2023) claim that the idioms of *dhiki*, *huzuni*, and *kufikiria sana* resonated with individual stress from the social world, *huzuni* associated with depression due to the loss of a loved one, and *kufikiria sana* relating to intense thinking about personal, familial, or professional distressing events. In Uganda, the Baganda cultural community views psychological distress like depression as madness or sadness (Asiimwe et al., 2023). They understand depression as *eByekika*, or clan illness or problems which manifest as mood-congruent delusions, and they also believe that the actions of the living toward the deceased cause this clan illness (Asiimwe et al., 2023).

In the Namibian context, a study by Claudius et al. (2022) was conducted on the expression of trauma amongst the Khoekhoegowab community. According to this study, this community used a common idiom of distress within their community to describe their traumatic experiences (Claudius et al., 2022). This idiom is the "*Tsûsa! Nae!khais xa hâ!nâ/mâ!nâ/=/ gâ!nâhe hâ*" which, according to Claudius et al. (2022), is directly translated as ("a terrible event has entered a person and remains standing inside"). This idiom highlights the significance of cultural expressions in understanding trauma, offering insights into how the Khoekhoegowab community conceptualize and communicate their suffering. Such culturally bound expressions are crucial for mental health practitioners to recognize, as they can inform more effective and culturally sensitive approaches to treatment and support within specific communities. Another study by Bartholomew (2022) focused on the Owambo community in Namibia. The term used for mental illness in this community is *eemwengu*, and it entails madness (Bartholomew, 2022). This term reflects not only the Owambo cultural context but also the community's interpretations of psychological suffering, highlighting how it may be viewed as a disruption of social harmony or a deviation from expected behaviors. Additionally, Bartholomew's research indicates that

the perception of *eemwengu* can influence help-seeking behaviors, as individuals may turn to traditional healers or community support systems rather than formal mental health services. Understanding the implications of such terms and expressions is crucial for mental health practitioners working with different communities, as it underscores the importance of culturally informed approaches to mental health care that respect local beliefs and practices.

Language plays an important role in help-seeking behavior, and this is demonstrated by a study by Dagsvold (2019) that mentions a minority community called the Sami in Norway who are limited to accessing mental health services mainly due to cultural and language barriers between clinicians and clients. Practitioners need to bridge cultural barriers when helping clients from multicultural backgrounds by being more culturally competent and exploring mental illness explanatory models of their clients (Bartholomew, 2022).

The importance of the etic and emic approaches becomes evident in the context of understanding the language, terms, concepts, idioms, and metaphors associated with mental illness. Thus, incorporating both the etic and emic perspectives is crucial for mental health professionals, as it equips them to understand not only the symptoms and diagnoses of mental illness but also the cultural meanings and expressions that shape their clients' experiences. This comprehensive understanding is vital for delivering effective, culturally competent care that honors the individuality of each client's mental health journey. Absent from the research is the language used to understand the expression of mental health among the Ovaherero community, which this study has addressed.

2.7 Cultural competence in mental health care

Cultural competence in mental health care has emerged as a crucial framework for enhancing outcomes and promoting equity in diverse societies. Culture influences how individuals perceive illness, express distress, seek help, and interact with interventions. Ogundare (2020) emphasizes that culture is complex, multilayered, and integral to mental health experiences; failure to account for cultural factors can result in harmful care, ineffective treatment, and reinforced disparities. Empirical studies consistently show that culturally incompetent care alienates patients, reduces treatment adherence, and undermines the therapeutic alliance (Bhui et al., 2007; Patel et al., 2018).

Bhui et al. (2007) demonstrate empirically that misunderstandings about cultural competence persist among practitioners. They report that some clinicians narrowly interpret cultural competence as mere knowledge of cultural customs or traditions, neglecting the more important task of understanding how cultural beliefs shape perceptions of illness, help-seeking behavior, and acceptance of interventions. Their review of evaluation models highlights how superficial approaches to cultural competence often result in tokenistic gestures, rather than genuine, effective engagement with cultural frameworks.

Hadwiger (1999), as cited in Bhui et al. (2007), offers an empirical definition of cultural competence as an ongoing process of engaging patients from diverse backgrounds, explicitly considering their cultural assumptions and attitudes when developing care plans. This process requires practitioners to avoid stereotypes and to foster instead individualized understanding of how each patient's cultural identity affects their mental health experience. These insights challenge practitioners to develop flexible and

responsive approaches to care that respect cultural variation, rather than imposing rigid, one-size-fits-all interventions.

Gone (2015) expands on these ideas with empirical evidence showing that culturally competent care requires practitioners to move beyond static cultural knowledge to dynamic, reflective practice. His research among Native American communities revealed that interventions perceived as culturally insensitive, even when clinically sound, were rejected by patients and families. He argues that culturally competent clinicians must develop humility and cultural reflexivity, recognizing their own biases and the limits of their knowledge, while working collaboratively with patients to co-construct meaningful care plans.

Steglitz et al. (2015) add empirical support by exploring the integration of evidence-based practice (EBP) with cultural competence. Their analysis shows that while EBP provides valuable scientific rigor to treatment approaches, its effectiveness depends on flexibility to adapt interventions to culturally diverse populations. They argue that combining EBP with cultural competence enables clinicians to leverage high-quality scientific evidence while tailoring interventions to align with cultural beliefs, values, and communication styles, ensuring that treatments are both practical and culturally acceptable.

Wieland et al. (2011), as cited in Bartholomew (2018), demonstrate that complementary and alternative treatments rooted in cultural beliefs can coexist with biomedical approaches when practitioners adopt a culturally competent stance. Their empirical study of refugee and immigrant populations in the United States demonstrated that integrating culturally familiar practices, such as herbal remedies or spiritual

counselling, with professional mental health care reduced stigma and increased engagement, providing a model for culturally congruent, hybrid interventions.

Patel et al. (2018), through the Lancet Commission on Global Mental Health, highlight that culturally competent care improves outcomes by aligning interventions with local explanatory models and addressing barriers such as language, stigma, and mistrust. Their empirical analysis across multiple countries reveals that patients are more likely to engage in treatment when they perceive providers as understanding and respectful of their cultural perspectives. Patel et al. argue that culturally competent mental health systems are essential for achieving equitable mental health outcomes in multicultural societies.

Bartholomew and Gentz (2019) provide a Namibian perspective, showing that despite a reported 12–13% prevalence of psychological distress in the country (MoHSS, 2005), few mental health professionals are available, and most are trained exclusively in Western counselling and psychiatric paradigms. Their qualitative research among practitioners revealed gaps in cultural competence, as clinicians struggled to reconcile Western models with local beliefs about mental illness, particularly among ethnic groups like the Ovaherero. This empirical evidence highlights the pressing need for culturally competent training programs to equip practitioners to work effectively across Namibia's diverse cultural landscape.

Claudius et al. (2022) extend these insights with research on indigenous communities in Namibia, demonstrating that practitioners unfamiliar with local idioms of distress often misinterpret symptoms, leading to misdiagnosis or culturally inappropriate interventions. Their interviews with community members highlighted frustration with providers who failed to recognize cultural expressions of distress, reinforcing mistrust

and discouraging future help-seeking. These findings affirm the empirical necessity of training practitioners to recognize, respect, and integrate local language and cultural narratives into clinical practice.

Nxumalo and Mchunu (2017) add empirical depth with their study on stigma in South African families affected by mental illness. They show that cultural competence in family-centered interventions is crucial, as cultural beliefs about the causes of mental illness shape family responses, caregiving practices, and openness to external help. Culturally competent interventions addressing family-level stigma reduced shame, improved communication, and enhanced treatment adherence, highlighting the importance of culturally responsive care strategies at both individual and family levels.

Cenat et al. (2024) and Jimenez et al. (2022) provide empirical evidence on how structural factors intersect with cultural competence. Their research shows that even culturally tailored interventions fail if they do not address systemic barriers such as racism, colonial histories, and socioeconomic inequalities. Cenat et al.'s systematic review reveals that practical cultural competence training for practitioners includes not only understanding patients' beliefs but also acknowledging historical and structural injustices that shape patients' mental health experiences. Jimenez et al. demonstrate that programs improving cultural competence among providers reduced disparities in service utilization among racially and ethnically marginalized older adults in the United States.

Mukolo et al. (2020) empirically confirm that culturally competent care can improve mental health outcomes in African settings when practitioners integrate local beliefs with psychosocial explanations of mental illness. Their research shows that when interventions acknowledge factors such as poverty, trauma, and social disconnection

alongside cultural and spiritual beliefs, they resonate more effectively with communities, thereby enhancing engagement and effectiveness. This approach counters the stereotype that patients in non-Western contexts reject biomedical models; instead, they seek care that is congruent with their lived realities.

Keikelame and Swartz (2019) demonstrate that cultural competence requires a willingness to incorporate traditional and faith-based practices where appropriate. Their empirical study in South Africa found that communities were more receptive to interventions combining biomedical treatments with pastoral counselling, traditional cleansing, or family rituals, as these respected cultural narratives about mental illness. Such hybrid models improved perceptions of credibility and reduced stigma, providing practical examples of culturally competent, integrative care.

Kohrt et al. (2016) highlight the effectiveness of community-participatory approaches in building cultural competence. Their empirical research in Nepal demonstrated that involving local stakeholders, such as community leaders, traditional healers, and affected families, in the design and delivery of mental health services fostered trust and ensured that interventions were aligned with cultural expectations. This participatory process improved utilization, reduced stigma, and facilitated culturally congruent mental health promotion.

Harasym et al. (2022) emphasise that cultural competence also involves understanding and using culturally specific idioms of distress. Their comparative research across multiple cultures shows that recognizing and validating idioms like "suffocated heart" or "thinking too much" allows clinicians to enter patients' cultural worlds, fostering trust and therapeutic alliance. Ignoring such idioms risks alienating patients or misinterpreting their symptoms, undermining the effectiveness of interventions.

Empirical research consistently demonstrates that cultural competence is not a static achievement, but rather an ongoing, dynamic process of learning, reflection, and adaptation. Bhui et al. (2007) caution that cultural competence must move beyond checklist approaches to include self-awareness of biases, active listening, and openness to diverse perspectives. Their findings highlight that cultural competence should be seen as a lifelong professional commitment rather than a one-time training.

Gone (2015) reinforces this by arguing that culturally competent practice requires critical engagement with the assumptions of Western psychology itself. Gone's (2015) research among Native American communities shows that mental health frameworks often reflect Western individualistic values that may not align with collective or relational cultural orientations, creating tensions that can only be resolved through genuine cultural humility and flexibility.

Steglitz et al. (2015) demonstrate empirically that evidence-based practice (EBP) and cultural competence can be reconciled when practitioners adapt scientifically validated interventions to cultural contexts rather than imposing rigid treatment protocols. Their findings suggest that EBP frameworks should include cultural adaptation as a standard component to ensure that interventions are both practical and acceptable across diverse populations.

Bartholomew and Gentz (2019) conclude from their Namibian research that cultural competence must include understanding historical factors, such as colonial legacies, that shape patients' trust in healthcare systems. Without acknowledging these broader socio-political contexts, cultural competence risks becoming superficial or ineffective. They argue that cultural competence training in Namibia should integrate historical awareness, local languages, and community-based approaches to mental health care.

2.8 Barriers to Accessing Mental Health Care and Equity

Accessing mental health care is a complex challenge for many individuals from culturally diverse and marginalized backgrounds, shaped by intersecting social, structural, economic, and cultural barriers. These barriers perpetuate disparities, undermine treatment outcomes, and limit the realization of mental health equity worldwide. Empirical evidence highlights that racism, language difficulties, financial constraints, stigma, inadequate infrastructure, and systemic discrimination are among the most significant obstacles preventing equitable access to mental health services (Cénat et al., 2024; Jimenez et al., 2022).

Cénat et al. (2024) provide comprehensive empirical evidence from their systematic review of racism and mental health disparities, demonstrating that both interpersonal and institutional racism significantly contribute to adverse mental health outcomes in marginalized communities. Their findings show that racism increases risks of depression, anxiety, post-traumatic stress, and suicidal ideation. Moreover, experiences of racism diminish trust in mental health systems, discourage help-seeking, and contribute to premature termination of treatment. This dynamic highlights the importance of addressing racism not only as a social injustice but also as a public health crisis directly impacting mental health equity.

Jimenez et al. (2022) empirically demonstrate how racism is embedded in healthcare systems in the United States, reinforcing inequities that extend beyond individual experiences to structural disadvantages. Their study on older adults of colour reveals that discriminatory policies, biased clinical practices, and underrepresentation of marginalized groups in healthcare leadership perpetuate disparities in diagnosis, treatment, and access to culturally competent care. These structural barriers increase

vulnerability to untreated mental health conditions and widen health disparities over time.

Aguwa et al. (2023) extend these findings to African contexts through their systematic review of barriers to mental health care in sub-Saharan Africa. They identify stigma, low mental health literacy, limited service availability, and prohibitive treatment costs as pervasive obstacles across multiple African countries. Their analysis shows that stigma rooted in beliefs about supernatural causes of mental illness discourages individuals from seeking care due to fear of social exclusion, reinforcing cycles of neglect and worsening psychological distress. Aguwa et al. emphasise that these barriers are compounded by inadequate mental health policies, poor resource allocation, and shortages of trained professionals, limiting the scalability of mental health interventions.

Komu et al. (2025) offer empirical insights into logistical and cultural barriers, noting that unreliable transportation, long distances to mental health facilities, and fears of confidentiality breaches discourage utilization of professional mental health services in rural and peri-urban areas of sub-Saharan Africa. Their systematic review highlights how cultural interpretations of mental illness—as spiritual punishment or witchcraft-induced—divert patients from formal health systems toward traditional or faith-based healing. These cultural barriers intersect with structural challenges, creating a complex web of impediments to accessing timely, effective mental health care.

Andrade et al. (2014), through the WHO World Mental Health Surveys, empirically identify both structural and attitudinal barriers to mental health treatment across 17 countries. Their findings reveal that low-income nations experience the highest levels of unmet mental health needs, driven by scarcity of services, financial hardship, and

negative attitudes toward mental illness. They show that even when services are available, individuals often delay or avoid treatment due to fears of stigma, lack of knowledge about mental health, and concerns over treatment efficacy. These empirical observations emphasise that barriers to mental health care are multifactorial, combining individual, community, and systemic factors.

The intersection of historical trauma and access barriers has been empirically demonstrated in Namibia, where colonization, apartheid policies, and prolonged armed conflict have entrenched disparities in mental health care. Claudius et al. (2022) highlight that Namibia's colonial legacies have shaped collective identities, reinforced hierarchical power structures, and fostered mistrust of formal institutions, including healthcare systems. Their interviews with indigenous communities reveal that historical injustices have left lingering effects on perceptions of mental illness, with many associating professional mental health services with external domination or cultural erasure. These empirical findings underscore the need to contextualize access barriers within historical and sociopolitical realities, particularly in formerly colonized societies.

Patel et al. (2018) empirically demonstrate that systemic inequalities and social determinants of health, such as poverty, education, and housing, are fundamental barriers to mental health equity. Their global research shows that marginalized populations face compounded disadvantages that limit access to mental health services and contribute to poorer outcomes. They argue that effective strategies for mental health equity must address these social determinants alongside culturally appropriate care, as health inequities are deeply intertwined with broader socioeconomic disparities.

Empirical evidence also highlights how language and communication barriers limit access and quality of care. Harasym et al. (2022) report that linguistic mismatches between patients and providers frequently result in misunderstandings, misdiagnoses, and poor therapeutic alliances. Their comparative study across diverse cultural groups shows that the absence of culturally and linguistically appropriate services deters individuals from seeking care, especially when mental health terminology does not resonate with local idioms of distress or cultural interpretations of suffering.

Nxumalo and Mchunu (2017) provide empirical support for the role of family dynamics and stigma as barriers to mental health care in African communities. Their study reveals that families often conceal mentally ill relatives to avoid social disgrace, resulting in delayed help-seeking or reliance on unregulated traditional interventions. This concealment is not simply a product of ignorance but a rational response to anticipated stigma and discrimination within communities lacking mental health literacy and supportive social structures.

Cénat et al. (2024) further demonstrate that discrimination based on intersecting identities—including race, gender, age, and socioeconomic status—amplifies barriers to mental health care. Their research shows that individuals facing multiple forms of marginalization experience compounded obstacles, such as increased exposure to violence, financial instability, and social isolation, all of which exacerbate mental health needs while simultaneously limiting opportunities for help-seeking.

Jimenez et al. (2022) also empirically show that systemic racism interacts with cultural and economic barriers to deepen disparities in mental health outcomes. Their findings indicate that racially marginalized older adults often avoid services out of fear of mistreatment, previous negative encounters, or lack of trust in clinicians who do not

share their cultural backgrounds or life experiences. Such barriers highlight the importance of diversifying the mental health workforce and implementing policies that foster equity and inclusion.

Aguwa et al. (2023) identify inadequate mental health infrastructure as a structural barrier in many African countries, where underfunding of mental health systems results in shortages of trained professionals, medications, and facilities. They note that the treatment gap in sub-Saharan Africa exceeds 75% in many settings, meaning most people with mental illness receive no formal care. Their empirical findings reveal that limited mental health resources not only constrain treatment options but also perpetuate stigma by signaling that mental health is not a priority within health systems.

Patel et al. (2018) emphasise that addressing these barriers requires systemic approaches, including investment in mental health services, policy reforms, and integration of mental health into primary care. Their research shows that task-sharing interventions, in which non-specialist community health workers are trained to provide basic mental health support, can bridge gaps in access, particularly in low-resource settings. These empirically supported models reduce barriers related to distance, cost, and provider shortages, offering scalable solutions to improve mental health equity.

Mukolo et al. (2020) argue empirically that effective strategies to overcome barriers must incorporate culturally sensitive health education campaigns to reduce stigma and improve mental health literacy. Their research among parents of children with mental illness in sub-Saharan Africa shows that culturally appropriate psychoeducation enhances understanding of mental health, challenges harmful beliefs about supernatural causes, and encourages timely help-seeking, ultimately reducing the treatment gap.

Komu et al. (2025) empirically confirm that community-based approaches addressing transportation and confidentiality concerns are critical to reducing barriers. They recommend decentralized mental health services within local communities and culturally safe spaces where individuals can seek help without fear of exposure or gossip. Their systematic review highlights that services perceived as respectful of privacy and cultural norms improve utilization and engagement.

Claudius et al. (2022) also emphasise the empirical need for culturally congruent interventions in Namibia, where historical inequities and cultural mistrust of formal institutions hinder access to mental health services. Their findings indicate that interventions co-developed with community leaders, incorporating local healing practices and language, are more likely to succeed by fostering trust and cultural safety.

2.9 Theoretical Framework

The theoretical foundation of this study was anchored in Arthur Kleinman's Explanatory Model (EM), a framework that is instrumental in understanding how different cultural groups interpret health and illness (Kleinman, 1980). Kleinman's model provided a robust structure for exploring the Ovaherero community's perceptions of mental health, particularly their beliefs about the symptoms, causes, and appropriate interventions for mental illness. The Explanatory Model emphasises that health and illness are not only biological phenomena but also deeply rooted in cultural beliefs, social structures, and individual experiences (Kleinman, 1980). This framework was particularly suited for this study, as it allowed for an in-depth analysis of how the Ovaherero community in the Opuwo urban area conceptualised mental health and illness, offering insights into the cultural factors that influence their understanding and responses.

The Explanatory Model has been widely applied in various cultural contexts to examine how different communities understand and respond to health issues. For instance, Abdullahi (2020) utilised Kleinman's model to investigate Somali refugees' perceptions of mental health in the United States, revealing how cultural beliefs influenced their understanding of mental illness and shaped their preferences for treatment. Similarly, Malpass et al. (2021) employed the Explanatory Model in their study on indigenous mental health in Australia, where they explored how cultural narratives around mental illness informed the community-driven approaches to mental health care. These applications of Kleinman's model demonstrate its relevance in cross-cultural mental health research, underscoring its utility in revealing the underlying cultural logics that guide health-related behaviours and beliefs.

In applying Kleinman's Explanatory Model to the Ovaherero community, this study focused on uncovering the specific cultural beliefs that shaped their understanding of mental health. The model was used to explore the community's interpretations of the symptoms and causes of mental illness, which often diverged from biomedical explanations and were instead rooted in spiritual or ancestral beliefs. This approach was critical in revealing the complexities of mental health within the Ovaherero context, where mental illness might be attributed to supernatural forces, ancestral displeasure, or spiritual imbalance, as suggested by similar studies in African settings (Keikelame & Swartz, 2019).

Furthermore, Kleinman's model facilitated the exploration of culturally endorsed interventions for mental health issues within the Ovaherero community. The study found that traditional healing practices, such as consultations with spiritual leaders or the performance of rituals, were often preferred over Western medical treatments. These

practices were deeply embedded in the community's cultural and religious fabric, reflecting the Explanatory Model's assertion that health interventions are often selected based on culturally specific understandings of illness (Napier et al., 2019). By applying this model, the study not only identified the preferred mental health interventions within the community but also provided a culturally sensitive analysis that respected the Ovaherero's beliefs and practices.

The use of Kleinman's Explanatory Model in this study also underscored the importance of cultural competence in mental health research. It allowed for a comprehensive examination of the Ovaherero community's mental health beliefs without imposing external interpretations, ensuring that the findings were grounded in the community's cultural context. This approach was in line with recent scholarly calls for culturally informed mental health research that prioritises the perspectives of the communities being studied (Mukolo et al., 2020). Overall, the Explanatory Model provided a powerful tool for analysing the cultural dimensions of mental health within the Ovaherero community, offering valuable insights into how cultural beliefs shape the understanding and treatment of mental illness.

2.10 Summary

In summary, this literature review highlights the crucial role of cultural beliefs in shaping perceptions, expressions, and responses to mental health and illness. It demonstrates that cultural contexts profoundly influence mental health experiences and interventions, with examples from diverse groups like the Tamang community in Nepal and Asian American immigrants underscoring the connection between cultural norms, stigma, and help-seeking behaviours. These findings underscore the need for culturally competent mental health services that incorporate local belief systems to enhance the effectiveness of interventions. However, there are gaps in the literature regarding

specific communities, such as the Ovaherero, where culturally tailored interventions are still underexplored. Drawing on the theoretical framework of Arthur Kleinman, this study aims to address these gaps by examining the Ovaherero community's cultural understanding of mental health, thereby contributing to a more inclusive approach in mental health care that respects diverse cultural perspectives.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter provided an overview of the research process. The current study employed a qualitative research approach with an ethnographic research design. This chapter highlighted and discussed the study population, sample, research instruments, data collection procedures, and data analysis. This chapter concluded with an examination of the research ethics observed throughout the study.

3.2 Research Approach and Research Design

This study employed a qualitative approach, utilising an ethnographic design. The qualitative approach was chosen to capture the subjective perspectives of individuals in a specific cultural setting, which enabled the researcher to explore how participants interpreted and responded to mental illness (Maree, 2016). Integrating this design provided a structured framework for investigating the Ovaherero community of Opuwo as a bounded system, allowing for an in-depth, contextually grounded examination of cultural understandings of mental illness. This approach aligned closely with the research objectives, as it facilitated a comprehensive exploration of cultural beliefs, practices, and norms surrounding mental illness within a clearly defined setting (Yin, 2018).

The ethnographic design was particularly suited to this study because it extended beyond the grounded theory by prioritising the discovery of cultural narratives and shared meanings associated with the phenomenon under investigation (Tavory & Timmermans, 2009, as cited in Bartholomew & Gentz, 2019). Through participant observation and in-depth interviews, the researcher engaged with community members in their natural environment, uncovering the nuances of their experiences and the

cultural frameworks they used to interpret mental illness (Hammersley & Atkinson, 2019). This immersive engagement was crucial for understanding how participants communicated their perceptions of mental illness and the interventions they considered effective within their cultural context (Babchuk & Hitchcock, 2013).

Significantly, the qualitative, ethnographic approach also facilitated the exploration of traditional interventions for mental illness, addressing the second specific objective of the study. By examining communal support systems, traditional healing practices, and culturally rooted beliefs, this method allowed participants to articulate what interventions they found meaningful and appropriate. The flexibility of qualitative research further enabled the adaptation of interview techniques as new themes emerged, ensuring responsiveness to participants' insights and the evolving nature of cultural beliefs. Overall, the ethnographic approach prioritised the voices and lived experiences of the Ovaherero community, ensuring the research remained culturally sensitive, contextually relevant, and reflective of the community's unique understanding of mental illness.

3.2.1 Research paradigm

This study was grounded in the constructivist research paradigm, which is particularly appropriate for qualitative research that seeks to understand how individuals and communities construct meaning within their specific cultural and social contexts. The constructivist paradigm is based on the ontological assumption that reality is not a singular, objective entity but is socially and experientially constructed by individuals (Lincoln & Guba, 1985). In this view, multiple realities exist, shaped by cultural, historical, and contextual factors.

The epistemological stance of constructivism holds that knowledge is co-created through interactions between the researcher and participants, rather than discovered as an objective truth (Creswell & Poth, 2018). The researcher's role, therefore, is to engage deeply with participants, interpret their experiences, and understand the meanings they attribute to phenomena—in this case, mental illness within the Ovaherero community. Constructivism acknowledges that the researcher's background and positionality inevitably influence the interpretation of data; hence, reflexivity becomes a critical component of the research process (Charmaz, 2014).

In the context of this study, the constructivist paradigm provided a philosophical foundation that aligns with the objective of exploring how Ovaherero individuals perceive, understand, and respond to mental illness based on their cultural frameworks. This paradigm allowed the researcher to focus on the subjective meanings and lived experiences of participants, acknowledging that these are shaped by collective cultural narratives, social interactions, and traditional belief systems (Patton, 2015).

Furthermore, the constructivist stance justified the use of qualitative ethnographic methods, as these methods are designed to capture in-depth, contextually rich data that reflect the participants' worldview. Techniques such as participant observation and semi-structured interviews enabled the researcher to co-construct knowledge with the Ovaherero community members, ensuring that the findings remained grounded in the participants' own expressions and interpretations.

3.3 Population of the Study

The population of this study consisted of the Ovaherero-speaking adults from Opuwo, Kunene region, aged 18 years and older. According to the 2023 Population and Housing

Census Preliminary Report, the total population of Opuwo Urban was 23,934, consisting of 12,749 females and 11,185 males (Namibian Statistics Agency, 2024).

3.4 Sample

This study employed two sampling methods: convenience sampling and homogeneous sampling. Convenience sampling involves selecting participants who are easily accessible to the researcher, allowing for practical and timely data collection, particularly when resources or time are limited (Maree, 2016). Homogeneous sampling, in contrast, focuses on selecting individuals who share key characteristics relevant to the research objectives; in this study, participants were chosen because they belonged to the Ovaherero community and shared a common ethnic background, enabling an in-depth exploration of cultural beliefs specific to this group. The sample comprised 15 adult participants aged 18 years and above. There was no specific gender ratio targeted in participant selection, and as a result, the sample did not aim for a predetermined balance between male and female participants. This sample size was deemed sufficient, as it provided rich, detailed data until thematic saturation was achieved, at which point no new significant themes emerged during the interviews (Bartholomew & Brown, 2022). By including adults over the age of 18, the study ensured a range of perspectives, depth of knowledge, and varied experiences, recognising that the exact number of participants needed for saturation may differ depending on the complexity of the topic and the population studied.

3.5 Research Instruments

This research study utilised a semi-structured interview and a socio-demographic questionnaire developed by the researcher, and informed by the literature on culture and mental health. These instruments were used for data collection, and the questions focused on the objectives of this study, which were to identify cultural meaning systems

related to mental health, explore Ovaherero community members' views on the symptoms and causes of mental illness, and identify perceived culturally appropriate mental illness interventions within the Ovaherero community. A wide range of socio-demographic variables were included, such as gender, age, cultural background, religion, fluency in English and Otjiherero languages, highest level of education attained, type of housing, living arrangements, parental status, household amenities, and ownership of livestock. (see Appendix C and Appendix D).

3.6 Data Collection Procedures

Ethical clearance was obtained from the University of Namibia's Decentralised Ethics Committee before commencing the research study (see Appendix A). The study was conducted in Opuwo, a town in the Kunene Region. Participants were recruited from the local organisations, including non-governmental organisations such as the Red Cross Society, and community-based organisations like the Shack Dwellers Federation of Namibia in Opuwo. The researcher approached these organisations, introduced the research study, and presented it to potential participants. Additionally, community members not affiliated with these local organisations were also recruited. The informed consent (see Appendix B) was read to the participants to ensure they understood the study before agreeing to participate. Based on their availability to participate in the study, volunteers were recruited and a written consent was provided.

Upon obtaining the ethical clearance certificate, the researcher conducted a pilot study. The pilot study was conducted to test the research instruments for content validity and to enable the researcher to become familiar with the interview process, particularly in practising reflexivity. The pilot involved three adult participants from the Ovaherero community in Opuwo who were not included in the main study sample. These individuals provided valuable feedback on the clarity, relevance, and cultural

appropriateness of the interview questions, allowing for necessary adjustments before data collection commenced. During the data collection phase, 15 participants were interviewed in groups of three at community centres and participants' homes in Opuwo. Group discussions allowed participants to validate and elaborate on each other's experiences, which enriched the data by capturing communal narratives and shared meanings around mental illness. This approach facilitated a more natural conversational flow, fostering openness and reducing the perceived formality of the interview process.

Additionally, logistical factors, such as the participants' availability and time constraints, made it practical to interview small groups rather than arranging multiple individual interviews. Grouping participants in threes ensured that the group remained small enough to allow each individual to contribute meaningfully, while also creating a supportive environment that encouraged discussion on culturally sensitive topics.

The interviews were conducted over two weeks to two months, with each session lasting approximately two to three hours. The researcher, proficient in Otjiherero, conducted interviews in Otjiherero with participants who did not speak English and with the elderly within the community, and subsequently translated the interviews into English for data analysis.

The interviews were audio-recorded to ensure an accurate account of participants' responses. When necessary, the leading researcher translated the interviews conducted in Otjiherero into English for transcription and analysis. However, the translation of the interview guide and transcripts was not independently verified by a professional translator or another Otjiherero speaker. This reliance on a single researcher for translation could be considered a potential limitation of the study, as it may have introduced unintentional biases or affected the accuracy of culturally nuanced

meanings. Throughout the interviews, the researcher remained attentive to participants' responses to identify new lines of inquiry relevant to the study's objectives, allowing for a flexible and responsive approach to data collection.

3.7 Data Analysis

The ethnographic approach allowed the researcher to build understanding from the ground up by focusing on cultural uniqueness and inductive conceptualisations through cultural engagement that developed beyond surface-level interaction with cultural group members (Bartholomew & Brown, 2022). Thematic analysis was used to analyse data obtained in this study following the six-phase approach outlined by Braun and Clarke (2006). The analysis began with familiarization with the data, where the researcher immersed herself in the interview transcripts by reading and re-reading them, while also listening to the audio recordings to ensure a comprehensive understanding of the content. This was particularly important for interviews conducted in Otjiherero, which were translated into English during this phase to preserve contextual meanings. Following familiarization, the researcher proceeded to generate initial codes by systematically identifying and labelling meaningful segments of data that reflected recurring ideas, beliefs, and cultural expressions related to mental illness.

The next phase involved searching for themes, where the researcher organised the codes into potential themes by grouping together patterns and concepts that shared common meanings. These preliminary themes were then reviewed and refined to ensure they accurately represented the coded data and the broader dataset, with some themes being combined, refined, or broken into sub-themes to capture nuanced interpretations. Once the themes were finalised, the researcher moved to defining and naming themes, where each theme was clearly defined and given a descriptive name that captured its essence and relevance to the research objectives.

The final phase involved producing the report, where the researcher provided a detailed narrative of the findings, supported by direct quotations from participants to illustrate key points. This phase also involved linking the themes back to the research questions and existing literature to demonstrate how the study contributed to the understanding of mental illness within the Ovaherero cultural context.

The data from the recorded interviews were transcribed and analysed using Microsoft Word processing software. Coding identified and isolated emerging similar statements related to the study's objectives and themes were then developed from these similar statements. The researcher also focused on the variations and similarities of the meanings attached to the studied phenomena by the participants.

3.8 Research Ethics

Ethical clearance was obtained from the University of Namibia's Decentralized Ethics Committee of the School of Allied Health Sciences and an informed consent was obtained before participants took part in the study. Participation was entirely voluntary, and participants were free to leave at any time without penalty. The researcher ensured that participants' best interests were considered and that no harm would come to them. This was done by prioritising their autonomy, confidentiality, and emotional well-being throughout the research process. Prior to participation, the researcher provided detailed explanations of the study's purpose, procedures, potential risks, and participants' rights, including the right to withdraw at any stage without any consequences. Participants were selected through convenience and homogeneous sampling, ensuring a fair selection. Identifiable information was kept confidential. The findings are to be shared with the broader research community and hopefully published in scholarly journals to add to the existing literature. Data, containing no identifiable personal details, were stored on the researcher's password-protected computer and will be kept for five years

before being securely disposed of. Several measures were involved in maintaining data confidentiality, such as converting data into code for data storage and transmission, completing restricted access controls, anonymizing information, securing physical storage, regularly updating security protocols like passwords, and complying with relevant data protection regulations. The main researcher has access to the data.

3.8.1 Ethical Principles

Adherence to ethical principles is a cornerstone of conducting responsible research, particularly in studies involving human participants. In this study, the researcher committed to upholding the ethical principles of beneficence, non-maleficence, and justice, as outlined by Greaney et al. (2012), to ensure the safety, dignity, and rights of all participants.

Beneficence, which requires the researcher to contribute to the welfare of participants actively, was maintained by prioritizing the well-being of every individual involved in the study (Greaney et al., 2012). The researcher ensured that the research process maximized potential benefits, such as contributing valuable insights for culturally relevant mental health interventions that could ultimately improve community well-being. To achieve this, participants were provided with opportunities to share their experiences in a safe and respectful environment, knowing that their input would be valued and inform the development of culturally competent mental health services.

Non-maleficence, a related but distinct principle, obligates researchers to avoid causing harm to participants, whether physical, emotional, social, or psychological (Greaney et al., 2012). Non-maleficence was upheld by taking proactive steps to minimize any risk of distress. The interviews were conducted in secure and comfortable settings chosen by the participants, ensuring privacy and confidentiality. Sensitive topics were

approached with care and empathy, allowing participants to skip questions they found uncomfortable or distressing. Furthermore, the researcher was vigilant for signs of distress during interviews and prepared to refer participants to appropriate mental health services if needed, thus prioritizing participant safety.

Justice, according to Greaney et al. (2012), demands fairness in the recruitment, selection, and treatment of participants, ensuring equitable distribution of the burdens and benefits of research. To honor this principle, the researcher designed recruitment strategies that offered equal opportunity for participation to all eligible adults in the Ovaherero community, without discrimination based on age, gender, education level, socioeconomic status, or mental health status. Recruitment materials and processes were culturally appropriate and communicated in the participants' preferred language to remove barriers to participation. This inclusive approach ensured a diverse representation of voices, reflecting the broad range of cultural understandings within the community.

To further protect participants' rights and ensure justice, informed consent was obtained prior to participation. Participants were provided with detailed explanations of the study's purpose, procedures, potential risks, benefits, and their rights, including the right to withdraw at any time without facing negative consequences. Consent forms were written in clear, understandable language, and where necessary, verbal explanations were provided to accommodate varying literacy levels. This process respected participants' autonomy by ensuring they entered the study voluntarily and with a complete understanding of what their involvement entailed.

In maintaining confidentiality, a key component of non-maleficence and justice, the researcher anonymized data by assigning pseudonyms to participants and securely

storing all records. Data were handled in strict accordance with ethical guidelines to prevent unauthorized access, ensuring that participants' identities and shared experiences remained protected. Audio recordings and transcripts were securely stored on password-protected devices accessible only to the researcher.

Moreover, the researcher engaged with community leaders prior to data collection to build trust and secure community-level consent, recognizing the collective nature of decision-making in many African communities. This approach aligned with the principle of justice by ensuring that the research respected local cultural norms and avoided imposing external frameworks on participants.

Finally, the researcher continuously reflected on their positionality, biases, and potential power dynamics throughout the research process. By acknowledging and actively managing these factors, the researcher aimed to minimize unintended coercion or influence, reinforcing beneficence and justice. Ethical approval for the study was sought and granted by the relevant institutional ethics review board, confirming that the research design met established ethical standards and that all safeguards were in place to protect participants' rights and welfare.

3.9 Procedural rigor

Procedural rigour in qualitative research, which refers to the systematic approach taken to ensure the trustworthiness, credibility, and reliability of the research findings, was ensured through various criteria. According to Schwandt, Lincoln, and Guba (2007), trustworthiness in qualitative research is often ensured through several criteria, including credibility, transferability, dependability, and confirmability. Credibility was established by utilising various data sources and techniques, such as supervised debriefing. The researcher underwent debriefing sessions with the supervisors.

Transferability, the ability to apply research findings to comparable situations, was achieved by providing in-depth explanations of the settings and methods used in the study.

Furthermore, dependability, which guarantees the consistency and validity of the study's conclusions, was maintained by keeping records of decisions and procedures and using precise, methodical approaches. Confirmability was achieved by allowing several researchers to evaluate the data and using reflexivity to reflect on their biases and presumptions, thereby ensuring impartiality and neutrality. To ensure the trustworthiness of the findings, the researcher ensured the credibility, dependability, transferability, and confirmability of the results.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the research findings following the analysis of the data obtained. The study aimed to identify cultural understandings of mental health and illness within the Ovaherero community. In addition, the findings from this study may help mental health practitioners develop appropriate interventions for clients with an Ovaherero cultural background by utilizing the information gathered, such as cultural meaning systems. The results are hereby presented with reference to the aim and the following two research objectives that informed this study:

- a) To explore cultural beliefs about the symptoms and causes of mental illness; and
- b) To identify the cultural interventions believed to be appropriate for mental health

The demographic data of the participants are indicated in *Table 1*, followed by a description of the socio-demographic data. Following this, a brief biographical description of the participants is stated, which includes pseudonyms, indicated by (*) (see APPENDIX E). The word "participant" and the given "pseudonym" will be used interchangeably. The themes and subthemes that emerged from the data will be presented and examined separately. Each theme will be explored in relation to the participants' lived experiences and insights. Participants shared their detailed conceptualizations of mental health and identified various barriers to interventions, as well as offered possible recommendations for potential interventions or improvements.

4.2 Socio-demographics

This section describes the sociodemographic characteristics of the 15 participants who took part in the research. Table 4.1 below provides detailed information on the characteristics of the research participants (n = 15), followed by a detailed description of the findings.

Table 4.1: *Socio-demographics of the research participants.*

Participant characteristics	Frequency (n=15)	Percentage (%)
Gender		
Male	9	60
Female	6	40
Age (years)		
Under 25	1	6.7
25-34	9	60
35-44	5	33.3
Cultural group		
Ovaherero	15	100
Religious Affiliation		
Protestant	7	46.7
Lutheran	2	13.3
Seventh-day Adventist	1	6.7
Roman Catholic	1	6.7
Non-Christian	1	6.7
Unaffiliated	1	6.7
Animism	2	13.3
Language Proficiency		
Fluent in Otjiherero	15	100
Fluent in English	13	86.7
Fluent in Afrikaans	1	6.7
Highest Obtained Educational Qualifications		
Secondary	7	46.7
Tertiary	8	53.3
Type of Dwelling		
Brick	14	93.3
Shack	1	6.7
Household composition		
Lives by themselves	11	73.3
Lives with family	4	26.7
Lives with their children	1	6.7
Living without their children	3	20
Children		
With children	4	26.7
Without Children	11	73.3
Number of Children		
1 child	2	33.3
2 children	2	33.3
Ownership of livestock		
Owns livestock	11	73.3
No ownership of livestock	4	26.7
Types of livestock		
Cattle	8	72.7
Goats	3	27.3

The socio-demographic data of the research participants reveal several key characteristics. The sample consists of 60% males and 40% females, with the majority aged between 25 and 34 years (60%), followed by those aged 35 to 44 years (33.3%), and a smaller proportion under 25 years (6.7%). All participants belong to the Ovaherero cultural group. Religious affiliations are diverse, with Protestantism being the most common (46.7%), followed by smaller representations of Lutheranism (13.3%), Animism (13.3%), and other religious groups. The majority of participants are fluent in both Otjiherero (100%) and English (86.7%), with only one person fluent in Afrikaans (6.7%). In terms of education, over half (53.3%) hold tertiary qualifications, including diplomas, honours degrees, and postgraduate qualifications, while 46.7% hold secondary education qualifications (Grade 12).

Additionally, most participants (93.3%) reside in brick houses, while a small percentage (6.7%) live in shacks. The household composition data indicate that 73.3% live alone, and among those with children, most (20%) do not live with their children. Additionally, 73.3% of participants do not have children, and of those with children (26.7%), 33.3% have two children each. A significant proportion of participants (73.3%) own livestock, primarily cattle (72.7%), while 27.3% own goats; none of the participants owned both cattle and goats. Livestock ownership was included as part of the demographic profile due to its significant cultural and socio-economic relevance within the Ovaherero community. In this context, livestock—particularly cattle—not only represents economic wealth but also serves as a symbol of cultural identity, social status, and community belonging. By collecting this information, the researcher aimed to contextualise participants' socio-economic backgrounds and explore how these cultural assets might influence perceptions and responses to mental illness. Additionally, livestock ownership can affect access to traditional support networks and

resources, which are integral in understanding coping mechanisms and intervention preferences within the community. Including this variable thus provided a richer, culturally grounded understanding of the participants' lived realities. This socio-demographic profile reflects a relatively young, educated, and predominantly Protestant sample, with strong cultural ties to the Ovaherero group, bilingual proficiency, and traditional practices such as livestock ownership.

4.3 Participants Biographical Information

Participant 1: Abby*

Abby* is a 28-year-old female nurse from Opuwo. She completed her primary education and her secondary education. She then went on to further her studies at a nursing institution, where she obtained a diploma in nursing. She is currently employed as a nurse.

Participant 2: Ben*

Ben* is a 32-year-old male police officer from Opuwo. He was born in a small village outside Opuwo. He completed his primary and secondary education. He then attended a tertiary institution, where he earned his degree in Geology.

Participant 3: Clara*

Clara* is a 24-year-old female nursing student from a small village outside Opuwo. She was born in Opuwo. She completed her primary and secondary education. She then took a gap from studies, and now she is studying nursing at a tertiary institution.

Participant 4: Dan*

Dan* is a 40-year-old male from Opuwo. He was born at the Opuwo State Hospital and spent most of his life in Opuwo. He completed his primary and secondary education. He then attended a tertiary institution, where he earned his degree in pharmacy. He is currently a pharmacist in Windhoek. He is married and has two daughters.

Participant 5: Ethan*

Ethan* is a 26-year-old male from Opuwo. He was born at the Opuwo state hospital. He started his primary and secondary education in Opuwo. He has a certificate in hospitality that he obtained at a Vocational Training center. Currently, he is unemployed.

Participant 6: Fred*

Fred* is a 25-year-old male from Opuwo. He completed his primary and secondary education. He did not further his studies. He is currently unemployed.

Participant 7: Gale*

Gale* is a 33-year-old female police officer from Opuwo. She completed her primary and secondary education. She has a two-year-old daughter who stays with her at the village, outside the town of Opuwo. She holds a Bachelor's degree in Information and Communication Technology, which she obtained from a tertiary institution. Currently, she is employed.

Participant 8: Helen*

Helen* is a 36-year-old female residing in Opuwo. She completed her primary and secondary education. She has a six-year-old son and a two-year-old daughter. She has a certificate in early childhood development. Currently, she is a substitute teacher.

Participant 9: India*

India* is a 26-year-old female from Opuwo. She was born in Opuwo and attended school there as well. Once she completed her secondary education, she started working at her family's take-away in Opuwo. She has not further her studied but plans to do so once she is able to afford it. She has no children..

Participant 10: Jason*

Jason* is a 32-year-old male from Opuwo. He was born in Opuwo and completed his primary and secondary education there. Currently, he is studying at a university in Namibia, pursuing a Bachelor of Education degree.

Participant 11: Kay*

Kay* a 36-year-old female from Opuwo. She was born in Opuwo. She completed her primary and secondary school. She works as a cleaner. She attempted further study, but was unable to do so due to personal reasons.

Participant 12: Larry*

Larry* is a 35-year-old male police officer from Opuwo. He completed his primary and secondary education. He lives in Opuwo.

Participant 13: Mathew*

Mathew* is a 32-year-old male from the Ovaherero community, residing in Opuwo urban. He is fluent in both English and Otjiherero, preferring to be interviewed in English. He is affiliated with the Christian community, single, and has livestock. His education includes a certificate in HIV/AIDS management.

Participant 14: Norris*

Norris* is a 35-year-old male residing in Opuwo. He is fluent in both English and Otjiherero, although he prefers to be interviewed in English. He holds a Bachelor of Education (Honors) degree in Lower Primary Education. Despite being non-religious, he maintains a strong connection to his cultural roots. He lives with his family in a brick dwelling that has access to water and electricity. However, he has one child who does not live with him. He owns goats and sheep that are kept at his father's homestead.

Participant 15: Ollie*

Ollie* is a 43-year-old male from Opuwo. He completed his primary and secondary education. He formerly worked for the Red Cross Society of Namibia in Opuwo but is currently unemployed.

4.4 Themes

Themes were derived from a total of 11 codes that were identified in the transcribed data and are presented in Table 4.2. These codes were grouped in a way that reflected common ideas or processes noted in the data. Which led to the identification of three themes, which are: (1) Beliefs about the causes of mental illness, (2) Cultural beliefs on symptoms of mental illness and (3) Interventions believed to be appropriate for mental illnesses. Sub-themes emerged from the identified themes (see *Table 4.3*). These

themes, along with their sub-themes, contribute to a comprehensive understanding of a unified conceptualisation of mental illness among the Ovaherero people.

Table 4.2: Codes

• Witchcraft – Mentioned by multiple participants as a cause of mental illness.
• Curses/Ancestral Influence – Belief that curses or violations of cultural taboos lead to mental illness.
• Stigma – Mental illness is associated with social exclusion and poor treatment.
• Traditional healers – The role of traditional healers in addressing mental illness.
• Substance abuse – Use of drugs and alcohol as a contributing factor.
• Family neglect – Families failing to seek help when someone shows signs of mental illness.
• Stress/Trauma – Stressful life events like financial strain or marital problems causing mental illness.
• Spiritual causes – Spiritual explanations beyond witchcraft (e.g., ancestral punishment).
• Medical knowledge – Modern medical and psychological explanations for mental illness.
• Cultural terminology – Terms like "Oviyoze" and "Omundu wavera omutima" were used by participants to describe mental illness.
• Environmental factors – Beliefs in the influence of the moon or weather on mental health

Table 4.3: The main themes and sub-themes

Main Theme	Sub-Themes
Beliefs about the causes of mental illness	<p>Definitions and Understandings of Mental Illness Cultural Understanding: Cultural Taboos and Supernatural Explanations; Mental Illness as a Social and Behavioural Deviation; Stress, Trauma, and Environmental Factors</p> <p>Dual Understanding and Hybrid Beliefs</p>
Cultural beliefs on symptoms of mental illness	<p>Behavioral Indicators</p> <p>Social Reactions</p> <p>Gendered Expectations</p>
Interventions believed to be appropriate for mental health	<p>Traditional and Spiritual Interventions</p> <p>Non-Traditional Interventions and Openness to Mental Health Services</p> <p>Barriers to Mental Health Care</p>

4.4.1 Beliefs about the causes of mental illness

4.4.1.1 Definitions and Understandings of Mental Illness

Many participants articulated definitions of mental illness using biomedical language, associating it with disorders that affect the brain, behavior, mood, and cognitive function. Participants frequently described mental illness in terms of psychological or emotional instability, impaired personal functioning, and disruptions in cognition. Standard terms such as "disorder" or "dysfunctional state of mind" reflected a clinical or scientific perspective influenced by exposure to biomedical concepts.

For instance, Abby* explained, "Mental illness is complex and conditions are many, and it is basically a condition that affects the brain and causes impaired personal functioning."

Similarly, Clara* described mental illness succinctly, stating, "Mental illness is a disorder and merely a dysfunctional state of mind."

Mental Illness as a Social and Behavioural Deviation

Many cultural conceptualizations of mental illness are centered on observable behaviors that deviate from societal norms. Participants emphasise behavioural symptoms such as public undressing, excessive alcohol consumption, or disrespecting elders as signs of mental illness. Reflecting a cultural focus on outward behaviors rather than internal cognitive or emotional states:

Mental illness is seen as acting "mad" or losing common sense. Fred* provides an anecdote about a young man who developed mental illness due to drug use, highlighting observable signs like physical deterioration, paranoia, and erratic behavior. This

reinforces the understanding that mental illness manifests in visible, tangible ways. He said,

"Yes, I know of a guy who was studying engineering. He was a first-year engineering student, and he started engaging in different illicit drugs, and he developed a mental illness. We could see him deteriorating slowly; he started talking to himself and running aimlessly. In the first few months, he appeared clean, but later, his skin became dark, especially his lips, and his eyes turned yellow. After a while, he was sent to a mental institution, he came back, and he was stable, but he was still not fine. He did not finish school "

Mental illness is framed as a disruption to a person's role in society, with an emphasis on social functioning rather than mental health as an individual's internal state. This is noted by Norris*, who said,

"Mental illness might mean someone who might be mentally unstable, meaning doing things that are not normal. For example, if you are not mentally fit as an adult, instead of wearing shoes, you will be walking barefoot and shirtless, insulting people, especially elders and drinking alcohol excessively. In my community, such people are considered to be mentally ill. Furthermore, the community perceives that these individuals lack the necessary skills and knowledge to be responsible. So less or nothing is required from them."

Adding to this, Kay* said,

"When they are not aware of their surroundings. They do abnormal things that are not culturally appropriated. They disrespect the elders and act however they want. Some may defecate and urinate anywhere, and when they are back to normal, they realize that what they do is abnormal. Some may act like that under the influence of alcohol,

while others without medication." These examples show how mental illness is conceptualized in relation to one's culturally expected role and behavior.

4.4.1.2 Cultural Understanding

In contrast, most participants often explain mental illness as resulting from supernatural or spiritual influences, such as witchcraft, curses, or ancestral punishment. Cultural taboos and societal norms are also emphasized, where breaking these norms can lead to illness. For instance, the consumption of certain forbidden foods or violating gender roles is seen as a trigger for mental illness.

Cultural Taboos and Supernatural Explanations

A recurring cultural theme is the belief that external spiritual factors cause mental illness. Participants frequently mention witchcraft, ancestral curses, and cultural disobedience as leading causes of mental illness. Examples include:

Breaking cultural norms, such as drinking *omaere* (sour milk) specifically when a woman is menstruating or touching certain animals, can lead to mental illness, as mentioned during the interview of Gale*, who mentioned,

"..... It is also believed that mental illness may result from witchcraft or from doing something that you are not supposed to be doing. For example, there is a belief that some people in certain families are not supposed to touch certain objects, or as a woman, you are not supposed to drink omaere while you are on your monthly menstruation. If the woman disobeys this rule and drinks omaere and maybe end up mad, the people will attribute that to her disobeying what she was told not to

do. This is knowledge we got from our parents, and they did not explain to us why things are the way they are."

Ancestral disobedience or societal norm violations, such as a village being cursed, are often thought to trigger mental disturbances. Out of the fifteen (15) participants, five (5) participants (1, 2, 11, 12 and 15) mentioned that disobeying ancestors or violating social norms may cause mental illness. Larry* provided an example, which is,

"...in my culture, there is a belief in the ancestors and that they are alive and that there certain things believed that certain families should not eat or touch. For example, certain families are not allowed to touch certain type of cows or eat a certain type of meat. Each family/household have different beliefs. When a person has a mental illness, people believe that something was done to the person. When this happened, they are taken to the holy fire, to get cleanse. There are also some villages that are believed to be cursed and there somethings that one is not supposed to do. For example, throwing water at night, they may go mad and they are supposed to go to the holy fire for cleansing ceremony."

In addition to this, Abby* also stated that,

"It is believed that mental illness is caused by witchcraft or curses from ancestors placed upon individuals doing something that they are not culturally allowed to do."

Words like "oviyoze" and "ombameno" are used to culturally describe individuals with mental illnesses, for an example, Ethan* mentioned that,

"...the words used to describe a mentally ill person is Oviyoze, which means crazy or omundu wavera oviyoze, meaning that person is sick mentally or is crazy."

In addition to this, Ollie* said

"When one feels (ombameno) meaning suffocated, stuck or trapped about a situation, and they feel like there is no way out, is when one may experience mental illness"

Gale* used similar terms like Ethan* when describing mental illness. However, she added another term also to describe mental illness, which is "omundu wavera omutima", meaning the person's heart is sick. She further explained this term by saying,

"I think it had to do with the fact that the heart was seen as the organ that has a person's life. Without your heart, I think it was believed that one may die. So, when one is mentally disturbed, the person may as well be dead, as there is no more normal life within that person. This is my understanding of it."

Stress, Trauma, and Environmental Factors

A more modern understanding of mental illness is also presented by some participants, linking it to life stress, trauma, and socio-economic pressures. Substance abuse also emerges as a key factor in the progression of mental illness. Participants describe instances where individuals turned to drugs or alcohol as a coping mechanism for trauma, which led to further mental deterioration. For example:

Mental illness is described as a response to life challenges, such as the death of loved ones, financial difficulties, or substance abuse. India* identifies behaviors such as being anti-social, constant arguing, unnecessary conflict, talking to oneself, and joking about suicide as signs of mental illness. These behaviors indicate that she sees both social withdrawal and disruptive behavior as key symptoms. She narrates a story about a young man who became homeless after his family mistreated him following his mother's death. This person turned to drugs, which led to his decline. This suggests that substance abuse is perceived as both a coping mechanism for unresolved trauma and a cause of further mental deterioration. She said,

"I know of one guy who used to stay in the family home but now is on the streets. His mother passed away when he was young. The mother was well off and his inheritance went to his aunty since he was the only child of his mother. The aunty started mistreating him and he left the house and when he got older, around 21, he went back to the aunty to get something like money to support himself from the inheritance. After this back and forth, he started using drugs as a coping mechanism. Now he is just roaming around, dirty and sleeping on the streets."

In addition to this, Jason* attributes mental illness to various factors, including unresolved trauma from childhood, growing up in an abusive environment, and substance abuse (drugs and alcohol). He mentions a specific case of someone whose mental state deteriorated due to excessive alcohol and drug use, leading to delusions and paranoia. When asked to provide a story, he said,

"Yes, I know of someone who was excessively using drugs and alcohol. These impacted his mental state and he has episodes for example, there

is a time when he comes back to reality and another time where his mentality is out of state. I do not know if the alcohol and drugs affected his mind or if he acts that way when he is sober. The absence of the substance may be a problem as well, the person is not mentally stable whether he drinks or when he is sober. No proper assessment was done to sufficiently know if it is the substance themselves or the effects of the substance. He becomes delusional and he starts thinking that people around him want to kill him or they hate him. It is mostly the people that he knows."

Environmental factors like poverty, neglect, and peer pressure are seen as contributing to mental health issues. Ollie* described this by saying,

"I believe that mental illness may result from stress that is excessive. This may cause someone to feel trapped especially when you are the eldest son and you are unemployed, and you are expected to support your family or your child. This may lead to that individual feeling trapped and may turn to alcohol, as this may help stop the thoughts for a moment. Unemployment and poverty amongst the youth really cause them to feel trapped and with no vision for their lives"

Ollie* also shared a story about the effect of drought on the mental well-being of individuals. He said,

"I was helping out at Red Cross and I moved around the villages surrounding Opuwo. There is an extreme drought going on right now, and people are suffering. This drought caused one man to commit

suicide as his cattle and goats were all dead. The men are supposed to take care of their families but due to this drought, they are helpless and they end up feeling really bad and some start using alcohol to cope."

Some participants relate mental illness to emotional and psychological pain, often resulting from heartache or loss. Ben* said,

"I believe that mental illness results from many things like substance abuse, too much stress, death, problems, etc. Any negative situation I think may result in someone having a mental illness. "

4.4.1.3 Dual Understandings and Hybrid Beliefs

Several participants exhibit a dual understanding of mental illness, combining both biomedical and cultural explanations. For instance:

Participants with a medical or educational background describe mental illness in terms of psychological and biological factors, such as chemical imbalances, but also acknowledge the role of witchcraft or curses in their cultural context. Most participants demonstrate a split between biomedical definitions of mental illness (e.g., affecting brain and behaviour) and cultural beliefs (e.g., witchcraft, curses, or breaking taboos). This dual understanding is evident in Abby, Clara, and Dan's interviews as mentioned below;

"Mental illness is complex and conditions are many, and is basically a condition that affects the brain and causes impaired personal functioning. Culturally, mental illness is viewed as an illness that is caused by witchcraft or curses from the ancestors." (Abby)

“Mental illness is a disorder or a dysfunctional state of mind. According to the beliefs within my culture, it is defined as an illness that is caused by witchcraft or curses from ancestors or doing something you are told not to do by your elders. These factors are thought to cause mental illness.” (Clara)

“Mental illness is any condition of the brain that affects a person’s behaviour, mood and concentration. In my culture, it is defined as an illness that is mostly caused by an evil spirit or curse from ancestors especially when one disobeys a cultural norm and when one acts out of what is normally expected.” (Dan)

4.4.2 Cultural Beliefs about Symptoms and Perceptions of Mental Illness

The participants gave various accounts of how mental illness presents and is viewed in their society. Their replies demonstrated a complicated interaction between visible behaviors, social reactions, and culturally influenced perceptions of mental illness.

4.4.2.1 Behavioral Indicators

Across all accounts, mental illness is predominantly associated with observable behaviors that deviate from societal norms, such as public nudity, aggression, confusion, talking non-stop with no context, self-harm, lack of awareness, mood swings, self-neglect, paranoia and inappropriate jokes. Participants frequently link these visible symptoms to broader cultural definitions of "madness" or "bewitchment" (Participants 1, 2, 5, 6, 8 and 10). Ben* believes that mental illness manifests differently compared to physical illnesses, noting that it is often harder for individuals to recognize their mental health issues due to the absence of physical pain. He describes individuals with mental illness as acting "like a mad person" or a "mentally disabled person". He said: *"Unlike physical illness, mental health is not painful; therefore, it's difficult for*

the patient to realize that they are sick and need medical assistance ". Another example is from Helen*, who identifies various signs of mental illness, including talking to oneself, acting scared, and discussing dead people. These behaviors, according to her, reflect the common symptoms of psychosis in her cultural context, where talking to oneself and aimless walking are viewed as key indicators of mental illness or being bewitched. She mentions that people diagnosed with depression often show signs like sadness, lack of eating, and prolonged sadness, suggesting that mental illness can manifest emotionally and physically. She said,

"They start talking to themselves, running and walking aimlessly, and they talk about dead people and wanting to go to the dead. They act like they are scared and talk about things that do not exist. The symptoms may vary according to what the illness is. For example, some people diagnosed with depression, they may not be eating and they may be feeling sad for a long period of time."

Jason* identifies inappropriate behavior, such as undressing in public, nonsensical speech, delusions, and poor judgment, as signs of mental illness. These behaviors suggest a lack of awareness of social norms and distorted perceptions of reality. He said,

"Mentally ill people behave inappropriately, like undressing, speaking nonsense, and they are delusional. They have an error in judgment when it comes to sensing danger or their surroundings, they do not know what to say and when, they have a distorted view of reality."

With one participant noting the cyclical nature of these symptoms worsening without medical intervention and improving with treatment (Kay*), the participant describes specific behaviors associated with mental illness, such as a lack of awareness of

surroundings, inappropriate actions (e.g., public defecation or urination), and speaking nonsense. She gives an example of a Himba woman who exhibited self-harm tendencies, such as trying to undress herself and threatening suicide. These symptoms are described as cyclical, worsening without medication and improving with treatment.

Yes, I know of a Himba lady who just normal who started getting physically ill and she started crying a lot. She started saying she wants to kill herself, and people will hold her, trying to prevent her from killing herself. She also tried to undress herself, and she started talking a lot and be overly active and start talking nonsense words that has no meaning. This was happening without the influence of substances such as alcohol or drugs. The family took her to the hospital, and she received help. When she is on medication, she gets better when the medication is done, she returns to be abnormal again." (Kay)

This emphasis on observable behaviors suggests that mental illness is often understood primarily through outward signs rather than internal or psychological factors. Additionally, there is a notable theme of differentiation between physical and mental health symptoms, with mental illness seen as less recognizable due to the absence of physical pain (Participant 2). This viewpoint likely contributes to delayed acknowledgement and treatment of mental health issues.

4.4.2.2 Social Reactions

Community reactions to mental illness are diverse but consistently marked by widespread neglect, ridicule, and misunderstanding. Participants describe various forms of social stigma, where individuals with mental illness are frequently marginalized, mistreated, or ignored until their condition worsens (Participants 8 and 9). According to Helen*, people in her community often make fun of individuals with mental illness or ignore them, until their condition worsens. This reflects a lack of

awareness and understanding of mental illness and suggests a level of stigma attached to those who have a mental illness. Only when the symptoms become severe do people realize the gravity of the situation. She said, *"Some people make fun of them, and sometimes they are ignored. They are made fun of and are not taken seriously. Until the condition becomes worse and they realize the person is in a serious problem."* In addition to this, India* indicates that mentally ill individuals are treated poorly within the community. They are seen as irrelevant and often abused, with people using them for entertainment or exploiting them for unpaid labour. She said, *"They are not considered/ are irrelevant. They are abused, for example, told to do chores, and they are not paid for their work. They are used as entertainment (recording them on social media platforms for laughs)."* This reflects a profound lack of empathy and understanding toward those with mental illness.

Moreover, Helen* attributes some responsibility for mental illness to the family's neglect. She highlights that family members may ignore early symptoms, fail to seek help, or continue to enable harmful behaviors, such as excessive drinking. This indicates a view where familial responsibility plays a significant role in both the onset and progression of mental illness. Some families, as noted by Kay*, may support mentally ill members, while others hide them due to shame, indicating that family perspectives powerfully shape individual experiences with mental health. Kay* said, *"In my community, it depends. Some people do not disclose their mentally sick people and some hide their sick. It depends on the family and their understanding of the illness. Some may treat them bad and some may treat them good. People need to be educated on mental illness so they understand the causes of it and not feel like it is curses on them."*

The community's reliance on supernatural explanations, such as witchcraft, instead of seeking psychological or medical interventions, compounds this neglect, as mentioned by Jason*, who notes that people with mental illness are seen as disabled or bewitched in his community, rather than being understood through a psychological lens. According to the participant, there is a lack of effort to explore the underlying causes, resulting in inadequate care or treatment. Jason said, "*In my community, they view those (mentally ill people) as people who are disable, they do not try to investigate what the underlying causes are. They think that it is either a disability from birth or witchcraft.*"

Across these accounts, there is a general lack of community support, often resulting in neglect, isolation, and even disrespect for those affected. For instance, mentally ill individuals may be shunned in public spaces, and their opinions are disregarded during community gatherings, as mentioned by participants 12 and 13. Mathew* said, "*They are not respected and their opinions are not regarded, especially when it comes to community gatherings. We do sympathize with them. The family tries to keep the person around and care for them.*" This treatment underscores the social isolation experienced by those with mental illness, as well as the profound stigma reinforced by community perceptions.

4.4.2.3 Gendered expectations

Gender expectations, particularly for males, also play a role in mental health perceptions. Participants mention that males, often in their 20s and 30s, face added vulnerability due to societal pressures to provide for their families, which may exacerbate their mental health challenges (Participants 4, 6 and 7). When asked who, according to their culture, is believed to be affected the most by mental illness (see Appendix C), Participant 4 identifies males aged 30 to 45 as the most affected. Fred*

believes that males between the ages of 23-35 are most affected by mental illness due to societal pressures to provide for the family, and this is illustrated by him saying, *“Everyone could be affected, but I think mostly men are affected around the ages of 23-35. Males go through a lot of pressure to fit in, and they are looked upon as providers for the family, and this can cause stress to the individual, and they may start engaging in alcohol or drugs to relieve some stress.”* Gale* mentioned that men aged 20-40 are most affected by mental illness due to societal pressures, and she also mentioned that vulnerable groups like the elderly and disabled are also at risk. Gale* said, *“Mostly males are affected around the ages of early twenties to late forties. I also think vulnerable people like the elderly may be affected, as some start to forget things, and I also think people with disabilities are also likely to be largely affected.”* This theme of male vulnerability suggests that social pressures around masculinity contribute to mental health issues, adding a layer of cultural expectation to the experience and expression of mental illness.

4.4.3 Interventions Believed to Be Appropriate for Mental Health

The participants shed light on the diverse, culturally influenced approaches to mental health interventions within the Ovaherero community, emphasizing both traditional and non-traditional methods, as well as the considerable barriers they encounter and the beliefs about treatment efficacy.

4.4.3.1 Traditional and Spiritual Interventions

The participants commonly describe traditional healers and rituals as primary intervention methods marked by the use of ancestral intercession, prophetic guidance, and spiritual rituals. Traditional practices, such as taking individuals to the holy fire (*okuruuo*) for ancestral intervention or consulting prophets who perform rituals like

otjimbali (bathing rituals), play a central role in the community's approach to mental illness (Participants 1, 2, and 5). Abby* indicated that, culturally, people with mental illness are taken to the holy fire for ancestral intercession or pastors/prophets for prayer. She said, *"They are taken for interventions to the holy fire for the intercession and help from the ancestors, and some are taken to pastors or prophets for prayer"*. Ben* describes interventions involving prophets who use herbal remedies and rituals, such as washing individuals in a basin called *otjimbali*. However, he admits to a lack of understanding regarding the specifics of these practices. He said, *"They are taken to the prophets here in Opuwo where they are being washed in a big basin called otjimbali. They use different herbs and I am not aware of what exactly these herbs are."* Furthermore, while aware of the traditional practice of the holy fire (*okuruuo*), Ethan* admits limited knowledge about how such methods help people with mental illness. He said,

"The mentally ill people are taken to the holy fire (okuruuo) where their family members ask for help from the ancestors to help bring their person back to normal. I am not sure exactly how it works, but I am aware of such practices"

Healers provide physical treatments using herbal remedies, but their role in treating mental illness is less clear or frequently involves spiritual practices, such as the holy fire (*okuruuo*) ceremonies and washing with herbal water (*ozombari*) to ward off curses or witchcraft, as stated by participants. These interventions are underscored by a strong belief in ancestral and spiritual guidance, where effectiveness often hinges on the individual's faith in traditional practices, as mentioned by participants 11 and 12. Kay* is aware of traditional healers who treat physical ailments using natural plants, but is

unsure whether they also provide treatments for mental illness. When asked if she knew of any traditional healer, she said,

"Yes, I know of one man who uses natural plants to treat people, for example, when you have diarrhea, he can get leaves from certain trees, boil them and let you drink that as a tea. I am not aware of him treating mental illness."

Larry* is aware of traditional healers; he emphasizes that they primarily treat physical ailments with natural herbs rather than mental illness. Mental illness is often addressed through spiritual interventions at the holy fire, where families seek ancestral guidance. However, the effectiveness of these ceremonies is viewed as uncertain, with a "50/50" chance of success, depending on the individual's belief. He said,

"I know of one traditional healer, but they do not treat mental illness. They only treat physical illnesses using natural herbs and not mental illness. In my community, it is difficult for someone who has a mental illness to be treated. They try going to the holy fire to contact the ancestors to ask for the cause and possible treatment for the individual. It works, depending on the person you ask, with a 50/50 chance. "

Mathew* indicates that traditional healers, often referred to interchangeably as witch doctors, are commonly consulted due to beliefs in witchcraft. These healers use herbs and perform rituals such as washing the individual with herbal water (*ozombari*) to cleanse them of curses or witchcraft. He said:

"I know of one healer, and what he does is use herbs and wash these individuals. We call them ozombari. They put these herbs in the water and wash the individual, believing that they are washing the witchcraft/curse away."

Ollie* highlighted the involvement of pastors and prophets as central figures in addressing mental illness, demonstrating how Christian beliefs are interwoven with traditional Ovaherero practices. According to Ollie*, many families seek help from pastors or prophets, who perform prayers, deliverance sessions, or anointing rituals believed to expel harmful spiritual forces causing mental distress. These religious leaders are often approached when families suspect witchcraft or ancestral displeasure as underlying causes, with the belief that spiritual intervention can restore mental well-being.

Adding further, Gale* and Helen* described how spiritual practices such as reading scriptures, attending church healing services, and collective family prayers serve as primary interventions for those experiencing symptoms of mental illness. They noted that older community members, in particular, prefer these faith-based approaches and are often hesitant to seek professional mental health services, perceiving traditional or Western treatments as less aligned with their values.

Family-based support structures also play a crucial role: extended family networks gather to discuss the affected individual's condition, consult elders for advice, and coordinate care through a combination of traditional remedies, spiritual practices, and emotional support. This communal approach reflects a strong belief in collective responsibility and underscores the importance of familial and spiritual interventions in managing mental illness within the Ovaherero cultural context.

4.4.3.2 Non-Traditional Interventions and Openness to Mental Health Services

Non-traditional services, including social workers and limited hospital care, are known but less widely utilized due to stigma, lack of information, and community unfamiliarity. Social workers' presence is noted, yet participants expressed skepticism

about their utility, with services often seen as ineffective without a local, culturally competent approach (Participants 13 and 15). Mathew* explains that people in his community are generally not open to using mental health services provided by social workers or psychologists. This is mainly due to a lack of information about these services and the strong cultural belief in witchcraft as the primary cause of mental illness. Psychologists are either absent from this community, or the community is unfamiliar with them. This limits formal mental health care access and contributes to continued reliance on familial and spiritual support. He said,

“In my culture, it is not common for people to use services that are provided by the social workers and psychologists. This is mainly due to lack of information on the type of services the social workers provide and also due to the reason of witchcraft. My people believe that they are witched.”

There is, however, a budding openness, especially among younger generations, toward non-traditional mental health services, although financial constraints and the stigma around seeking outside help, particularly for men, pose challenges. This cultural expectation of male self-reliance reinforces a belief that seeking professional mental health care, especially for men, signifies weakness (Participants 12 and 14). Larry* is aware of social workers but notes that their services are not widely accepted. There is a belief that seeking professional help (especially for men) indicates weakness. Men are expected to confide only in family. He said,

“They are not really open to these services. It is only a certain percentages of people. There is a belief that when someone seeks these services, they are believed to be too soft. As a man, you are not allowed to talk your problems with strangers. Confide in your family and keep it there.”

In addition, Norris observed that in Opuwo, psychologists and social workers are scarce, although some community members expressed a willingness to utilize their services if they were more accessible. However, cultural stigma remains, particularly among men, regarding seeking help. He said,

“Most people are not open. The ones who are educated are open to using the services; however, they, too, are ignorant. They are also influenced by the culture. For example, they believe that as a man, you are supposed to deal with your problems like a man and not go seek help. If you go to the social worker’s or psychologists, you are then regarded as weak.”

Kay* observes a gradual acceptance of mental health services, signaling that modern interventions could gain traction with increased awareness and education. The generational divide is pronounced, as older individuals exhibit strong preferences for keeping issues within the family, reflecting cultural norms that prioritize privacy and familial support over professional intervention (Participants 7, 9, and 10). Gale* believes the older generation is not open to seeking non-traditional mental health services, preferring to rely on family. This contrasts with younger individuals, who may be more open, but still face barriers to access. When asked if the people within her community are open to using non-traditional interventions, she said,

“I believe that it is because the older generations are mostly not informed about the specific services that are available, and they prefer confiding in their immediate family members than strangers”.

While younger people may be more open to seeking help from social workers or other professionals, India* stated that older individuals in the community may be more

resistant to such services, relying instead on traditional or familial support. She said, *“People are open to non-traditional services; however, it is mostly young people and not necessarily the older people.”*

4.4.3.3 Barriers to Mental Health Care

Stigma and denial remain significant obstacles, often leading families to hide mentally ill individuals to avoid public shame. Cultural beliefs around witchcraft and ancestral causes of mental illness further divert people from medical or psychological treatments, reinforcing reliance on traditional healers and spiritual interventions, as indicated by Mathew*, who said,

“In my culture, it is not common for people to use services that are provided by the social workers and psychologists. This is mainly due to lack of information on the type of services the social workers provide and also due to the reason of witchcraft. My people believe that they are witched.”

Additionally, education gaps in understanding mental health, particularly the lack of mental health awareness from government sources, compound these barriers by perpetuating misinformation, as Kay* said, *“people need to be educated on mental illness so they understand the causes of it and not feel like it is curses on them. The government need to start spreading awareness of mental health, especially this side of the country”*

Participants also identify language and cultural disconnects with existing mental health services, suggesting the need for more culturally and linguistically tailored care as indicated by Ollie* who said, *“...language barrier also cause people to not seek help as most social workers only speak*

English and they are also not culturally sensitive as they may not understand how certain practices are done.”

A significant barrier to utilizing formal mental health services is the community's limited access to and awareness of non-traditional mental health resources, particularly psychologists. Participants consistently mention social workers, who are sometimes accessible through state hospitals, but they also note the general absence of psychologists, which limits options for clinical mental health interventions (Participants 1, 3, and 4). This lack of resources is compounded by a cultural reluctance to seek formal psychological help, especially among older community members, who often view professional services with skepticism or mistrust (Participants 2 and 3).

The cultural emphasis on privacy and familial support is another critical factor contributing to low engagement with mental health services. Participant 4 highlights that privacy norms discourage people from seeking help outside the family, reinforcing a strong sense of familial responsibility and a reluctance to disclose personal struggles to outsiders.

Moreover, these findings suggest a gap in mental health literacy, with participants pointing to a lack of understanding regarding the benefits of professional mental health services. Ethan* notes that limited knowledge about psychological services and their potential benefits further discourages community members from utilizing these resources. He said,

“I believe that it is because people are not informed about those services and the benefits of such services. It is only a few people that use these services and that know the importance of these services.”

4.4.3.4 Beliefs about Treatment Efficacy

The perceived effectiveness of treatment is closely tied to cultural beliefs and values. Participants generally believe that traditional healing works for those who have faith in its methods, while medications are seen as beneficial, particularly for substance-abuse-related mental illnesses. However, adherence to medication is low due to stigma and a tendency to abandon treatment once initial symptoms subside, leading to relapse (Participants 13 and 14). Mathew* believes that the effectiveness of traditional healing practices depends on the individual's belief in those practices. For those who believe in witchcraft and traditional methods, such treatments are likely to work because belief plays a crucial role in the healing process. He said, *“To those who practice that, it works for them. I believe that an individual belief in a particular solution normally works for them. Belief is important in any treatment. That is what I think”*

4.5 Summary of findings

The findings of this research reveal a complex tapestry of cultural beliefs and practices surrounding mental health within the Namibian Ovaherero community, situated in the Opuwo urban area of the Kunene region. The study shows that understandings of mental illness are intricately interwoven with spiritual, social, and moral components, rather than being seen just as a medical issue. Participants revealed a variety of cultural attitudes on the origins of mental illness, demonstrating the complicated interplay between biomedical and cultural perspectives. Some participants held dual beliefs by incorporating both perspectives. Participants believe that external spiritual forces like witchcraft and curses cause mental illness. This view reinforces a larger cultural narrative that portrays mental health concerns as spiritually induced, resulting in a significant preference for traditional interventions over non-traditional interventions.

The study also discovered that mental illness is frequently associated with moral and social norm breaches, with some individuals seeing it as punishment for breaking cultural standards or taboos. Aggression, confusion, and a lack of personal hygiene were recognised as signs of mental illness in the population. Participants revealed traditional and non-traditional interventions for mental illness. Participants indicated that belief in treatment efficacy was crucial for the intervention process. Barriers to mental health care, such as language, were also identified.

CHAPTER FIVE DISCUSSION OF FINDINGS

5.1 Introduction

Chapter five discusses the implications of the findings presented in chapter four by contextualising them within relevant literature. As previously noted, this study aimed to identify cultural understandings of mental health and illness within the Ovaherero

community. This discussion synthesises the key findings in relation to the research objectives, which are to explore cultural beliefs about the symptoms and causes of mental illness and to identify the cultural interventions believed to be appropriate for mental health, as well as the implications these findings may have.

5.2 To explore cultural beliefs about the symptoms and causes of mental illness among the Ovaherero community

The first objective of this study was to explore cultural beliefs about the symptoms and causes of mental illness among the Ovaherero community. Through Kleinman's Explanatory Model, this exploration reveals how participants' beliefs form a culturally constructed narrative that defines mental illness not merely as a medical condition but as a social, spiritual, and moral disruption. According to Kleinman (1980), explanatory models are culturally informed cognitive frameworks people use to make sense of illness, specifying what the illness is, what caused it, and how it should be treated. This framework provides a powerful tool for understanding the duality in participants' beliefs, which straddle biomedical concepts and traditional cultural explanations.

Several participants demonstrated biomedical understandings of mental illness, describing it in clinical terms related to brain dysfunction, emotional instability, and impaired personal functioning. For instance, Abby* stated that "mental illness is complex and conditions are many; it is basically a condition that affects the brain and causes impaired personal functioning." This definition aligns closely with Kleinman's notion of etic perspectives—universal or outsider views grounded in biomedical or Western paradigms. Participants like Clara* reinforced this biomedical framing, referring to mental illness as a "disorder" and a "dysfunctional state of mind." Such perspectives suggest that exposure to modern education and health systems influences

the explanatory models held by some community members, as Kleinman argues occurs when individuals encounter dominant biomedical discourses.

The presence of biomedical language among participants with higher education or professional backgrounds reflects an emerging awareness of scientific explanations of mental illness. However, importantly, these understandings rarely exist in isolation. Even among these participants, cultural explanations remain deeply intertwined, revealing the duality Kleinman describes in communities where traditional and modern health beliefs coexist.

For many participants without formal medical education, mental illness was predominantly attributed to supernatural or cultural causes, including witchcraft, ancestral displeasure, and violation of cultural taboos. Ben* articulated a common belief, stating, “Mental illness is caused by someone bewitching you because they are jealous or angry with you.” This explanation reflects Kleinman’s emphasis on the social dimension of illness, where causes are rooted in relationships, social tensions, or perceived moral failures.

This perspective aligns with studies from other African contexts. For example, Asimwe et al. (2023) and Sorsdahl et al. (2010) describe how beliefs in bewitchment and ancestral wrath remain widespread explanations for mental illness in Uganda and South Africa, respectively. Nwoye (2020) notes similar patterns in various African communities, where abrupt or unexplained mental disturbances are frequently attributed to spiritual or moral causes, reaffirming the cultural validity of the explanatory models identified in this study.

The study also revealed that mental illness is often identified through visible behavioural indicators rather than internal emotional states, underscoring the

importance of observable signs in Ovaherero explanatory models. Participants cited behaviors such as aggression, disorientation, neglect of hygiene, nonsensical speech, and public undressing as primary markers of mental disturbance. Jason* described mental illness as manifesting through “inappropriate behavior like removing clothes in public, talking nonsense, or seeing things others do not see.”

Kleinman’s EM helps explain this emphasis: communities interpret illness through culturally sanctioned markers of normalcy and deviance. Observable behaviors that violate social expectations are therefore perceived as definitive evidence of mental illness. This is supported by literature such as Mkhize and Kometsi (2020) and Atilola (2019), who found that many African cultures prioritize external behaviors in identifying mental illness, equating visible deviance with psychological instability.

In addition to cultural explanations, participants demonstrated an emerging understanding of mental illness as a response to stress, trauma, and adverse life circumstances. This shift towards psychosocial interpretations reflects what Kleinman describes as the integration of personal experience into explanatory models, where individual narratives about suffering intersect with cultural beliefs. For example, India* described mental illness as a “reaction to life stressors,” recounting how a young man turned to substance abuse after losing his mother and facing mistreatment by his relatives. This narrative situates mental illness within the context of trauma and social hardship, broadening community understanding beyond purely spiritual causes.

This finding aligns with Pang et al. (2018), who identified stress and recent trauma as significant factors in mental illness explanations across cultures. Mkhize and Nkomo (2022) also observe a growing recognition in African communities of the role of poverty, trauma, and social isolation in mental health challenges, suggesting an

evolving explanatory model that incorporates both cultural and psychosocial dimensions.

The study further revealed gendered dynamics in perceptions of mental illness, with participants noting that men aged 25 to 40 are seen as particularly vulnerable due to social and economic pressures. Dan* highlighted that men in this age range “carry the weight of family expectations,” leading to heightened risk for mental health problems. This insight reflects Kleinman’s assertion that social structures, such as gender roles, are integral to explanatory models, influencing how communities perceive their susceptibility to illness.

Research by Kheswa and Makofane (2019) supports this, showing how African men experience elevated mental health risks due to cultural demands for financial provision and stoicism. This gendered dimension illustrates that explanatory models are not static but shaped by evolving social realities, which determine who is perceived as at risk and why.

Throughout participant narratives, a dual explanatory model emerged: many community members recognized both traditional cultural causes and modern biomedical or psychosocial explanations. This blend is central to Kleinman’s EM, which posits that people often negotiate between multiple belief systems to construct personal and collective meanings of illness. Abby* exemplified this, simultaneously acknowledging mental illness as “a brain condition” while cautioning that “jealous people can cause it through witchcraft.”

This duality aligns with Subudhi’s (2014) differentiation of the medical and social models of mental illness. While the medical model emphasizes biological and neurological dysfunctions, the social model highlights cultural, relational, and

structural causes. Participants' perspectives demonstrate how these models coexist in the Ovaherero community, with illness attributed to both neurochemical imbalances and spiritual disruptions, depending on the context.

Participants' belief in witchcraft and ancestral displeasure as causes of mental illness reflects enduring cultural continuity, as theorized by Kleinman, who argued that explanatory models often remain stable across generations unless disrupted by significant sociocultural change. For example, Ben* described mental illness as the result of curses from angered ancestors, a belief mirrored in findings by Mufunda et al. (2021), who documented that witchcraft accusations frequently arise in contexts of social tension, reflecting unresolved conflicts or jealousy within families or communities.

Thomas (2007) similarly found that in Caprivi (Zambezi region of Namibia), witchcraft serves as an explanation for unexplained health issues, demonstrating how these beliefs persist across time and regions. These consistent narratives demonstrate how cultural frameworks offer communities a means to explain and respond to complex experiences of distress, thereby fulfilling a core function of Kleinman's EM by restoring a sense of meaning and control.

5.3 To identify cultural interventions for mental illness within the Ovaherero community

The second research objective was to identify cultural interventions for mental illness within the Ovaherero community. Participants described interventions rooted in spiritual practices, traditional healing, and family-based support, highlighting how culturally congruent approaches remain the preferred means of addressing mental

health challenges. Kleinman's Explanatory Model provides an essential lens here, as it emphasizes that interventions are chosen based on locally constructed beliefs about illness causation and culturally defined pathways to healing (Kleinman, 1980).

Traditional healers occupy a central role in Ovaherero interventions for mental illness. Participants described healers diagnosing afflictions through divination, interpreting symptoms as signs of witchcraft or ancestral displeasure, and prescribing herbal remedies or rituals for spiritual cleansing. Mathew* detailed ozombari, the washing of individuals with herbal-infused water, as a key intervention for cleansing curses, illustrating the explanatory model's emphasis on cultural treatments matching perceived spiritual causes.

Abby* described the holy fire ritual (okuruuo), where families gather around a sacred fire to seek ancestral guidance and intervention for individuals with mental illnesses. This ritual reflects Kleinman's assertion that culturally meaningful practices provide legitimacy to both the explanation of illness and its treatment, thereby enhancing community acceptance and perceived effectiveness.

Similar findings are documented by Gureje et al. (2020), who observed that traditional and faith healers across Africa are not merely alternatives to biomedical care but form the primary mental health system for many communities. Bartholomew (2018) also highlighted how Namibian communities use ancestral rituals to address mental distress, reaffirming that such interventions are deeply embedded in local explanatory models.

Some participants reported consulting pastors or prophets alongside traditional healers, reflecting the significant role Christian beliefs play in shaping the Ovaherero community's responses to mental illness. Ollie* explained that pastors conduct prayers, deliverance sessions, and anointing rituals to "expel evil spirits" believed to

cause mental disturbance, demonstrating the community's faith in spiritual warfare as a means of restoring mental health. These practices highlight the integration of Christian worldviews with traditional understandings, illustrating an evolving explanatory model in which biblical interpretations of mental affliction coexist with indigenous explanations rooted in witchcraft and ancestral displeasure.

Participants described how churches sometimes organize healing services or deliverance crusades specifically targeting mental illness, with congregants laying hands on affected individuals or anointing them with oil, actions perceived as powerful spiritual interventions. This approach aligns with Christian teachings about the authority of faith and prayer to overcome evil, emphasizing the belief that mental disturbances can result from demonic oppression rather than purely medical or psychological causes.

Kleinman's Explanatory Model suggests that explanatory models are dynamic and adapt to new cultural and religious influences. This integration of Christian and traditional beliefs exemplifies that adaptability. The findings resonate with research by Keikelame and Swartz (2019), who reported that in South Africa, many communities seamlessly blend Christian teachings with traditional practices, seeking healing through both pastors and traditional healers. This hybrid approach reflects a culturally embedded understanding that mental illness can stem from both spiritual and physical causes, requiring multifaceted interventions that engage both faith and cultural heritage.

Participants described families as central agents in mental health care. Helen* noted that family members often act as first responders, observing symptoms, consulting elders, and organizing treatment through traditional or spiritual channels. When

symptoms are interpreted as spiritual afflictions, families may collectively seek ancestral or pastoral interventions before considering professional services. This reflects Kleinman's point that social relationships shape explanatory models and treatment choices.

However, as some participants observed, family support can be a double-edged sword. When families neglect early signs of mental illness, such as aggression or social withdrawal, it often leads to worsening symptoms. This neglect reflects underlying stigma, as families may fear shame or social repercussions if mental illness is acknowledged publicly. Nxumalo and Mchunu (2017) similarly documented how stigma-related family dynamics delay or prevent timely intervention.

Although traditional and spiritual interventions dominate, the study also revealed cautious openness among some younger participants to non-traditional mental health services, including counselling by social workers or treatment by psychologists. India* expressed interest in professional help, highlighting that life stressors, such as bereavement or financial hardship, might be better addressed through psychological support.

However, barriers such as stigma, lack of mental health literacy, and financial constraints continue to hinder engagement with formal services. As participant 11 noted, social workers are often mistrusted or misunderstood because "nobody explains what they do." This insight reflects Kleinman's assertion that interventions failing to align with local explanatory models struggle to gain acceptance.

Studies by Patel et al. (2018) and Bartholomew (2018) confirm that the credibility of mental health interventions in African communities is contingent on cultural fit. When

services do not align with community beliefs, they are either avoided or used only as a last resort.

Overall, the findings related to cultural interventions directly address the second research objective: identifying culturally specific ways of managing mental illness. Kleinman's Explanatory Model provides a framework for understanding why traditional healers, ancestral rituals, and faith-based practices remain central interventions because they align with shared cultural narratives about illness causation and healing.

At the same time, the emergence of openness to professional services among some participants signals a shifting explanatory model, where community members increasingly acknowledge modern psychosocial contributors to mental illness. However, for non-traditional services to be effective, they must engage with local explanatory models and address stigma and systemic barriers that impede access.

5.4 Chapter Summary

The results of this study demonstrate that mental illness in the Ovaherero community is understood through explanatory models that integrate cultural, spiritual, social, and biomedical elements. Interventions, symptoms, and causes are interpreted within a framework shaped by collective beliefs and social norms, highlighting the importance of culturally sensitive approaches to mental health care. Through Kleinman's lens, it becomes clear that acknowledging and respecting local explanatory models is essential for designing effective mental health services that resonate with the lived experiences of indigenous communities.

CHAPTER SIX

CONCLUSION, LIMITATIONS, STUDY STRENGTHS AND RECOMMENDATIONS

6.1 Introduction

This study aimed to examine cultural understandings of mental health and illness within the Ovaherero community, focusing on two key objectives: exploring cultural beliefs regarding symptoms and causes of mental illness and identifying culturally appropriate interventions. The study's purpose was to explore cultural concepts that shape the understanding and meaning of mental health in the Ovaherero community of Opuwo Urban, Kunene Region. Thus, the aim and research objectives influenced this study.

6.2 Conclusion

This study has provided an in-depth examination of the Ovaherero community's conceptualisations of mental health, highlighting how cultural beliefs, language, and traditional practices shape their understanding and responses to mental illness. By applying Kleinman's Explanatory Model, the research emphasises that mental health is not solely a biomedical issue but is deeply embedded in the cultural and social fabric of the Ovaherero people. Terms like *oviyoze* and *ombameno* illustrate the community's unique language and idioms used to describe psychological distress, conveying notions of being trapped, mentally troubled, or even experiencing a sickness of the heart. These cultural expressions align with findings from other studies in African and global contexts, demonstrating the value of idioms of distress in articulating culturally bound understandings of mental health. This study, therefore, not only expands the literature on Ovaherero mental health perspectives but also underscores the necessity for culturally informed mental health interventions that resonate with and respect the values of specific communities.

6.3 Limitations

This study faced several limitations that could affect the generalizability and scope of its findings. First, the research was conducted within a specific urban area (Opuwo), which may not fully capture the diversity of Ovaherero perspectives on mental illness across different regions or rural communities. The use of a qualitative design and a small, non-random sample limited the breadth of viewpoints, meaning the perspectives gathered may not represent the full spectrum of beliefs within the broader Ovaherero community in Namibia. Some participants, although culturally belonging to the Ovaherero community of Opuwo, were residing in neighbouring communities or working outside Opuwo during the time of data collection. While these participants

maintained strong cultural ties and familiarity with the community's beliefs and practices, it is acknowledged that their physical absence from Opuwo may have influenced their perspectives, potentially introducing elements of external influence or acculturation. This could affect the extent to which their insights fully represent the views of individuals currently residing within Opuwo. Nevertheless, their inclusion was deemed valuable for capturing a broader cultural understanding, given their ongoing participation in Ovaherero cultural practices and community life. Future studies could consider focusing exclusively on residents living within the immediate geographical area to enhance representativeness.

Additionally, convenience sampling resulted in a participant group with a narrow age range, excluding many older adults whose experiences and beliefs may differ significantly from those of the participants. The gender distribution among participants was also imbalanced, limiting the ability to compare male and female perspectives on mental illness comprehensively. Most participants were relatively young and had higher levels of education, which may have shaped their openness to biomedical explanations or modern treatment methods, potentially underrepresenting more traditional viewpoints. The researcher acknowledges that group interviews carry certain limitations, particularly in the context of sensitive topics such as mental health. Participants might have withheld personal information or refrained from fully disclosing their experiences due to the presence of others, thus potentially limiting the depth of individual responses. Additionally, group dynamics may have influenced certain participants to conform to dominant views expressed within the group, which may have affected the authenticity of individual perspectives.

A key methodological limitation was that the researcher translated the interview schedule and transcripts alone without independent verification through back-translation by another Otjiherero speaker or professional translator. This introduces the possibility of mistranslation or loss of culturally nuanced meanings, which could affect the accuracy of participants' intended messages. Finally, while the study focused on cultural interpretations of mental illness, it did not systematically explore how these beliefs intersect with external influences, such as exposure to Western mental health frameworks, which could also shape perceptions and help-seeking behaviors.

6.4 Study strengths

Despite these limitations, the study has several strengths. By adopting an ethnographic design grounded in Kleinman's explanatory model, it provided rich, in-depth insights into the cultural understandings of mental illness within a specific Namibian community. Conducting interviews in participants' preferred language allowed for more authentic expressions of beliefs, and the flexible, open-ended interview format enabled the exploration of unexpected themes. The findings contribute valuable knowledge for developing culturally sensitive mental health interventions and highlight the importance of engaging with local meaning systems when designing mental health services for indigenous communities.

6.5 Recommendations and implications for practice

The objectives of the study were met; however, there remains potential for further enhancement. The research elucidated the cultural understandings, causes, symptoms, and culturally endorsed interventions related to mental illness. Additionally, it identified the language used to express these issues. Mental health practitioners need to recognize culturally held beliefs in order to facilitate effective interventions.

Addressing barriers to intervention is equally crucial, as this will enable practitioners to understand better the necessary actions to support the community effectively.

The recommendations and implications for practice emphasise the need for culturally informed interventions in mental health care. Mental health practitioners should recognize that treatment plans must align with how patients perceive the nature and causes of their illnesses (Elliot et al., 2013). Understanding patients' varying beliefs about psychological treatment and their cultural interpretations of distress alleviation is crucial (Bartholomew, 2018). The belief in treatment significantly influences the effectiveness of interventions, as cultural contexts shape the acceptability and credibility of specific treatments. If a treatment is not culturally accepted, its efficacy diminishes. Thus, psychotherapy and Western interventions, such as psychopharmacological treatments, are not the only viable options for addressing psychological distress; cultural differences impact how mental illnesses are treated.

6.6 Recommendations for further research

Further research should focus on expanding the geographical and demographic scope of this study to include rural areas and a broader cross-section of Ovaherero individuals, providing a more comprehensive understanding of mental health beliefs within this community. Additionally, a comparative analysis involving other Namibian communities could offer valuable insights into how cultural and linguistic differences influence mental health interpretations across the nation. Researchers may also benefit from using a mixed-methods approach, combining quantitative data on mental health prevalence and treatment preferences with qualitative insights, to gain a more comprehensive understanding of mental health needs within the community. The inclusion of the older population (50 years and over) may provide rich data on cultural

belief systems and mental health, as their views may differ from those of the younger population. Finally, studies should explore the impact of exposure to Western mental health services on traditional beliefs, examining how cultural and biomedical understandings of mental health coexist, adapt, or conflict within the Ovaherero context. These recommendations aim to enhance culturally sensitive mental health support and contribute to a more inclusive understanding of mental health across diverse communities.

REFERENCES

- Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review, 31*(6), 934–948. <https://doi.org/10.1016/j.cpr.2011.05.003>
- Abdullahi, A. (2020). Cultural perceptions of mental health among Somali refugees in the United States: An application of Kleinman’s explanatory model. *Journal of Immigrant and Minority Health, 22*(5), 1234–1242. <https://doi.org/10.1007/s10903-019-00937-4>
- Aguwa, C., Carrasco, T., Odongo, N., & Riblet, N. (2023). Barriers to treatment as a hindrance to health and wellbeing of individuals with mental illnesses in Africa: A systematic review. *International Journal of Mental Health and Addiction, 21*(4), 2354–2370. <https://doi.org/10.1007/s11469-022-00847-4>
- Akintunde, A., Ndlovu, T., & Nkala, S. (2021). The role of stigma in mental health in African societies: Insights from community-based studies. *Journal of African Psychology, 7*(2), 45–63.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., Kessler, R. C. (2014). Barriers to mental health treatment: Results from the WHO World Mental Health surveys. *Psychological Medicine, 44*(6), 1303–1317. <https://doi.org/10.1017/S0033291713001943>

- Asiimwe, R., Nuwagaba-K, R. D., Dwanyen, L., & Kasujja, R. (2023). Sociocultural considerations of mental health care and help-seeking in Uganda. *SSM – Mental Health, 4*, Article 100225. <https://doi.org/10.1016/j.ssmmh.2023.100225>
- Atilola, O. (2019). Understanding mental health perceptions in African communities: The significance of cultural factors. *African Journal of Psychiatry, 12*(4), 76–89.
- Bartholomew, T. T. (2018). Beliefs about the treatment of mental illness among the Namibian Aawambo: An exploratory study. *International Perspectives in Psychology: Research, Practice, Consultation, 7*(4), 258–275. <https://doi.org/10.1037/ipp0000093>
- Bartholomew, T. T., & Brown, J. R. (2022). Entering the ethnographic mind: A grounded theory of using ethnography in psychological research. *Qualitative Research in Psychology, 19*(2), 316–345. <https://doi.org/10.1080/14780887.2019.1708170>
- Bartholomew, T. T., & Gentz, S. G. (2019). “How can we help you?” Mental health practitioners’ experiences of service provision in northern Namibia. *Culture, Medicine and Psychiatry, 43*(3), 496–518. <https://doi.org/10.1007/s11013-018-9616-3>
- Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research, 7*, Article 15. <https://doi.org/10.1186/1472-6963-7-15>

- Bhugra, D., Till, A., & Sartorius, N. (2013). What is mental health? *International Journal of Social Psychiatry*, 59(1), 3–4.
<https://doi.org/10.1177/0020764012463315>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Cénat, J. M., Broussard, C., Jacob, G., Kogan, C., Corace, K., Ukwu, G., Onesi, O., Furyk, S. E., Bekarkhanechi, F. M., Williams, M., Chomienne, M. H., Grenier, J., & Labelle, P. R. (2024). Antiracist training programs for mental health professionals: A scoping review. *Clinical Psychology Review*, 108, Article 102350.
- Chen, S. X. (2010). From emic to etic: Exporting indigenous constructs. *Social and Personality Psychology Compass*, 4(2), 118–130.
- Chase, L. E., Sapkota, R. P., Crafa, D., & Kirmayer, L. J. (2018). Culture and mental health in Nepal: An interdisciplinary scoping review. *Global Mental Health*, 5, Article e27.
- Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Sage Publications.
- Claudius, M., Shino, E. N., Job, S., Hofmann, D., & Thalmayer, A. G. (2022). Still standing inside: A local idiom related to trauma among Namibian speakers of Khoekhoegowab. *International Journal of Environmental Research and Public Health*, 19(21), Article 13920.
- Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.

- Dagsvold, I. (2019). Cultural adaption of mental health services to the Sami: A qualitative study on the incorporation of Sami language and culture into mental health services.
- Elliott, M., Maitoza, R., & Schwinger, E. (2012). Subjective accounts of the causes of mental illness in the USA. *International Journal of Social Psychiatry*, 58(6), 562–567.
- Goyal, D., Rabemananjara, K. M., Lara-Cinisomo, S., & Le, H. N. (2023). Healthcare workers' understanding of perinatal depression and maternal mental health service needs in rural Kenya. *Mental Health & Prevention*, 29, Article 200268.
- Greaney, A. M., Sheehy, A., Heffernan, C., Murphy, J., Ní Mhaolrúnaigh, S., Heffernan, E., & Brown, G. (2012). Research ethics application: A guide for the novice researcher. *British Journal of Nursing*, 21(1), 38–43. <https://doi.org/10.12968/bjon.2012.21.1.38>
- Gureje, O., Nortje, G., Makanjuola, V., Oladeji, B., Seedat, S., & Jenkins, R. (2020). The role of traditional and faith healers in mental health care in Africa. *The Lancet Psychiatry*, 7(1), 39–48. [https://doi.org/10.1016/S2215-0366\(19\)30264-3](https://doi.org/10.1016/S2215-0366(19)30264-3)
- Haidet, P., O'Malley, K. J., Sharf, B. F., Gladney, A. P., Greisinger, A. J., & Street, R. L. (2008). Characterizing explanatory models of illness in healthcare: Development and validation of the CONNECT instrument. *Patient Education and Counseling*, 73(2), 232–239.

- Hall, L. (2009). Conceptions of mental illness: Cultural perspectives and treatment implications. *Quadrivium: A Journal of Multidisciplinary Scholarship*, 1(1), Article 3. <https://nsuworks.nova.edu/quadrivium/vol1/iss1/3/>
- Harasym, M. C., Raju, E., & Ayeb-Karlsson, S. (2022). A global mental health opportunity: How can cultural concepts of distress broaden the construct of immobility? *Global Environmental Change*, 77, Article 102592.
- Hammersley, M., & Atkinson, P. (2019). *Ethnography: Principles in practice* (4th ed.). Routledge.
- Hwang, W. C., Myers, H. F., Abe-Kim, J., & Ting, J. Y. (2019). Culturally tailored mental health services for Asian Americans: A review of literature. *Cultural Diversity and Ethnic Minority Psychology*, 25(1), 1–14. <https://doi.org/10.1037/cdp0000164>
- Jimenez, D. E., Park, M., Rosen, D., Joo, J. H., Garza, D. M., Weinstein, E. R., Conner, K., Silva, C., & Okereke, O. (2022). Centering culture in mental health: Differences in diagnosis, treatment, and access to care among older people of color. *American Journal of Geriatric Psychiatry*, 30(11), 1234–1251.
- Kafula, M. N., Ugburo, E., & Kibuule, D. (2020). Consumption of psychotropic medicines at a referral hospital in Namibia: Findings and implications. *African Health Sciences*, 20(2), 1000–1010. <https://doi.org/10.4314/ahs.v20i2.40>
- Karthick, S., & Barwa, S. (2017). Culture and mental health: A review of culture-related psychiatric conditions. *Psychology and Behavioral Science International Journal*, 5(5), Article 555673. <https://doi.org/10.19080/PBSIJ.2017.05.555673>

- Keikelame, M. J., & Swartz, L. (2019). African spirituality and the use of traditional healing practices for people living with epilepsy in a South African community. *Epilepsy & Behavior*, *94*, 149–154. <https://doi.org/10.1016/j.yebeh.2019.02.020>
- Keikelame, M. J., & Swartz, L. (2019). Decolonising research methodologies: Lessons from a qualitative research project in Cape Town, South Africa. *Global Health Action*, *12*(1), Article 1561175. <https://doi.org/10.1080/16549716.2018.1561175>
- Keyes, C. L. M. (2005). Mental illness and mental health: The benefits of a dual conceptualization. *Clinical Psychology: Science and Practice*, *12*(2), 125–137. <https://doi.org/10.1093/clipsy.bpi014>
- Kheswa, J. G., & Makofane, M. (2019). Gender, culture, and mental health: Exploring the experiences of African men. *Journal of Cultural Studies in Psychology*, *5*(1), 23–35.
- Kirmayer, L. J., & Ryder, A. G. (2016). Culture and psychopathology. *Current Opinion in Psychology*, *8*, 143–148. <https://doi.org/10.1016/j.copsyc.2015.10.013>
- Kirmayer, L. J., & Swartz, L. (2019). Culture and global mental health. In D. Bhugra, K. Bhui, & S. Wong (Eds.), *Mental health of refugees and asylum seekers* (pp. 25–45). Oxford University Press. <https://doi.org/10.1093/med/9780198835551.003.0003>
- Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. University of California Press.

- Kleinman, A. (1997). Social suffering and the cultural politics of health: Perspectives and new directions. In R. Wilkerson (Ed.), *Culture and mental health: A comprehensive textbook* (pp. 33–60). Oxford University Press.
- Luminita, S. M., & Skandalaris, M. A. (2023). Social perception of mental illness. *Technium Social Sciences Journal*, 51, 282–296. <https://doi.org/10.47577/tssj.v51i1.10516>
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.
- Maree, K. (Ed.). (2016). *First steps in research* (2nd ed.). Van Schaik Publishers.
- Malpass, A., Westcott, A., & Robinson, H. (2021). Indigenous mental health and the role of culture in Australia: Applying Kleinman’s explanatory model. *Australian Journal of Social Issues*, 56(2), 245–261. <https://doi.org/10.1002/ajs4.1603>
- Mirza, A., Birtel, M. D., Pyle, M., & Morrison, A. (2019). The role of causal beliefs and stigma in White British and South Asians.
- Mkhize, N., & Nkomo, N. (2022). Traditional healing and mental health: Bridging the gap between indigenous and Western approaches. *Journal of African Health*, 5(3), 112–128.
- Mufunda, E., Mkhwanazi, A., & Ndlovu, S. (2021). Witchcraft beliefs and mental health in Southern Africa: Historical perspectives and contemporary challenges. *African Studies Review*, 64(2), 289–305. <https://doi.org/10.1017/asr.2021.33>
- Mukolo, A., Heflinger, C. A., & Wallston, K. A. (2010). The stigma of childhood mental disorders: A conceptual framework. *Journal of the American Academy*

of Child & Adolescent Psychiatry, 49(2), 92–103.
<https://doi.org/10.1016/j.jaac.2009.10.011>

Namibian Statistics Agency. (2024). *2023 population and housing census: Kunene regional profile*. <https://nsa.org.na>

Napier, A. D., Ancarno, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., & Woolf, K. (2014). Culture and health. *The Lancet*, 384(9954), 1607–1639.

Nwoye, A. (2020). The impact of cultural beliefs on mental health in African communities. *International Journal of Psychology and Counseling*, 12(1), 29–41.

Nxumalo, C. T., & Mchunu, G. G. (2017). Exploring the stigma-related experiences of family members of persons with mental illness in a selected community in the iLembe district, KwaZulu-Natal. *Health SA Gesondheid*, 22, 202–212.

Ogundare, T. (2019). Cultural beliefs and mental health: A case study of Yoruba traditional healers. *Journal of Cross-Cultural Psychology*, 50(8), 997–1010.

Ogundare, T. (2019). Journal of Health and Social Sciences advance publication online published online December 15. *The Italian Journal for Interdisciplinary Health and Social Development*.

Orley, J. H. (1979). *Culture and mental illness: A study from Uganda*. Makerere Institute of Social Research; East African Publishing House.

Pang, S., Subramaniam, M., Lee, S. P., Lau, Y. W., Abdin, E., Chua, B. Y., Picco, L., Vaingankar, J. A., & Chong, S. A. (2018). The Singaporean public beliefs about

the causes of mental illness: Results from a multi-ethnic population-based study. *Epidemiology and Psychiatric Sciences*, 27(4), 378–387.

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., ... Unützer, J. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet*, 392(10157), 1553–1598.

Patton, M. Q. (2015). *Qualitative research & evaluation methods* (4th ed.). Sage Publications.

Schwandt, T. A., Lincoln, Y. S., & Guba, E. G. (2007). Judging interpretations: But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Evaluation*, 2007(114), 11–25. <https://doi.org/10.1002/ev.223>

Sorsdahl, K. R., Flisher, A. J., Wilson, Z., & Stein, D. J. (2010). Explanatory models of mental disorders and treatment practices among traditional healers in Mpumalanga, South Africa. *African Journal of Psychiatry*, 13(4), 284–290.

Steglitz, J., Warnick, J. L., Hoffman, S. A., Johnston, W., & Spring, B. (2015). Evidence-based practice. In J. D. Wright (Ed.), *International encyclopedia of the social & behavioral sciences* (2nd ed., pp. 332–338). Elsevier. <https://doi.org/10.1016/B978-0-08-097086-8.10540-9>

Subudhi, C. (2014). Culture and mental illness. [Conference paper]. <https://doi.org/10.13140/2.1.1117.4724>

- Swartz, L. (1998). *Culture and mental health: A southern African view*. Oxford University Press.
- Swartz, L., Kilian, S., & Meda, M. (2019). Cultural interpretations and the care for people with mental illness: Insights from South Africa. *Transcultural Psychiatry*, 56(4), 567–582. <https://doi.org/10.1177/1363461519844647>
- Thabane, M., & Ratshivhanda, M. (2020). Navigating the tension between tradition and modernity: Understanding cultural interpretations of mental illness in rural African settings. *Global Health Review*, 8(2), 98–110.
- Thomas, F. (2007). “Our families are killing us”: HIV/AIDS, witchcraft and social tensions in the Caprivi region, Namibia. *Anthropology & Medicine*, 14(3), 279–291. <https://doi.org/10.1080/13648470701476186>
- Tylor, E. B. (1871). *Primitive culture*.
- Vranckx, C. H. (1999). Notes from Namibia: Assessing mental illness in a multicultural developing country. *International Journal of Mental Health*, 28(3), 3–43. <https://doi.org/10.1080/00207411.1999.11449406>
- World Health Organization. (2011). *Mental health atlas 2011*. World Health Organization. <https://apps.who.int/iris/handle/10665/44697>

Appendix A: Ethical clearance certificate



ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: SAH75/23

Date: 29/01/2024

This Ethical Clearance Certificate is issued by the University of Namibia Decentralized Ethics Committee (DEC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the School of Allied Health Sciences Decentralized Ethics Committee.

Title of Project: AN EXPLORATION OF THE UNDERSTANDING OF MENTAL HEALTH: A CASE STUDY OF THE OVAHERERO COMMUNITY, OPUWO URBAN AREA, NAMIBIA

Principal Researchers: RIJAMA THESSA MAUNDU

Staff Number: 201504226

Centre for Research Services

Take note of the following:

1. Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the ethics committee. An application to make amendments may be necessary.
2. Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the ethics committee.
3. The Principal Researcher must report issues of ethical compliance to the ethics committee (through the Chairperson) at the end of the Project or as may be requested by the ethics committee.
4. The ethics committee retains the right to:
 - i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
 - ii) Request for an ethical compliance report at any point during the course of the research.

The ethics committee wishes you the best in your research.

A handwritten signature in black ink, appearing to read 'T.W. Shumba', is written over a horizontal line.

Dr T.W. Shumba (Chairperson, Ethics Committee)

A handwritten signature in black ink, appearing to read 'Davis Mumbengegwi', is written over a horizontal line.

Prof. Davis Mumbengegwi (Head, Multidisciplinary Research)

Appendix B: Research participant information and consent form

Research participant information and consent form

Title: AN EXPLORATION OF THE UNDERSTANDING OF MENTAL HEALTH: A CASE STUDY OF THE OVAHERERO COMMUNITY, OPUWO URBAN AREA, NAMIBIA

Principle Investigator: Rijama Thessa Maundu

Student Number: 201504226

Supervisor: Dr S Gentz (University of Namibia)

Co-Supervisor: Dr T Bartholomew (Scripps College, United States)

Key Information

We kindly request your participation in this research study. Please pay close attention when reviewing this information. It is important to fully understand what this study is about and the importance of your involvement; therefore, do not hesitate to ask questions to the researcher about terms you do not fully understand. Your participation in this study is entirely voluntary, and you may choose not to take part/or leave at any moment without any negative consequences. Please note that if you choose not to participate, you will not be negatively affected in any way; however, if you decide to participate, you will be required to sign the form below.

This study will be conducted in accordance with the ethical guidelines and principles of the Research and Ethics Committee of the University of Namibia.

Purpose of this study

The purpose of this study is to explore the understanding of what mental health and illness are, within the adult Ovaherero community in Opuwo. This study intends to explore how the Ovaherero cultural community understands what the

causes of mental illnesses are and what culturally appropriate interventions are used to help people with mental illnesses. The researcher will be asking you questions regarding your views on mental health and illnesses. Please note that your answers will be voice-recorded, with your permission.

Why have I been requested to participate?

The researcher is interested in knowing what your understanding is regarding mental health/illness within your culture.

What will happen if I choose to take part in this study?

You will be interviewed by the researcher, and this will be done individually.

The interview will take approximately thirty (30) to sixty (60) minutes.

Are there any potential benefits in the participation of this study?

This information will be used to support Namibian mental health workers to offer high-quality care and to create specific clinical and culturally relevant treatments for mental illnesses.

What are the possible risks and discomfort?

There might be some cultural information you might not be willing to disclose. Please note that the researcher will not force you to disclose information you are not comfortable sharing. Please also note that you are free to leave the interview at any time despite the time allocated above, with no penalty.

Will I be paid to be in this study?

You will not be paid to participate in this study.

Will my information and participation be kept confidential?

Your identifiable information will not be disclosed to any person. Your feedback will be kept confidential; however, note that it may be reviewed by my supervisors and the board responsible for research regulations at the University of Namibia. The information you provide will be kept on the password-protected personal computer of the researcher. At no point will your identity be linked to the data you provide. The researcher will transcribe the interview and delete the digital recording of the interview immediately upon completion of the transcription.

What are my rights if I take part in this study?

Your participation in this study is voluntary. You may choose not to participate or, if you agree to participate, you can withdraw your participation at any time without penalty.

Who can I contact if I have questions about the study?

If you have questions, comments, or concerns about this research project, please contact:

Principal Investigator:

Rijama T Maundu

University of

Namibia

Email:

[tessamaundu](mailto:tessamaundu@gmail.com)

[@gmail.com](mailto:tessamaundu@gmail.com)

Supervisor:

Shelene Gentz, Ph.D.

Lecturer, Human

Science

University of

Namibia

sgentz@unam.n

a

Note: If you have questions about your rights while taking part in the study, concerns, or complaints about the treatment of your participation in this study, please contact:

The University of Namibia Research Ethics Committee at +264 061 206 3111/3199

Documentation of Informed Consent

By signing here, I acknowledge that I have read this consent form and have been informed about the research study. I was given the opportunity to ask questions concerning the research study, and my inquiries were answered. I understand that my involvement is entirely voluntary, and I am willing to

take part in the research study stated above. After I sign this consent form, I will be given a copy of it.

Signed at (*place*) on (*date*)2023.

Participant's Signature	Date

Participant's Name	Signature of witness

Declaration of the researcher

I declare that I have communicated the material in this document to the above-mentioned participant by signing below. I encouraged them to ask questions and took the time to respond. I am confident that the participant comprehends all parts of the research as indicated above. I did/did not use an interpreter.

Signed at (*place*) on (*date*)
2023.

Researchers Signature	Date

Appendix C: Interview Guide

Research Interview Protocol

Topic: An exploration of the understanding of mental health: A case study of the Ovaherero

Community, Opuwo urban area, Namibia

1. Please introduce yourself.

1.1 Tell me more about yourself.

2. According to your understanding, what is mental illness?

2.1 How would you define mental illness according to your culture? State what words are used to describe mental illness within your culture.

2.2 Are you aware of any cultural beliefs regarding mental illness? If yes, state what they are.

2.3 How is mental illness different from a physical illness? How are they similar?

2.4 Does your culture influence your understanding of mental illness? If yes, how?

2.5 Does your cultural background influence your understanding of mental illness? If yes, in what ways?

3. What are your cultural beliefs regarding mental illness (psychological problems)?

3.1 What beliefs do you have about mental illness?

Do you have any Ovaherero stories about people who have psychological problems (mental?

Illness)? If yes, please state.

3.2 How do you know if somebody has psychological problems (mental illness)?

3.3 Please provide examples of how someone who is regarded as having mental illness acts.

3.3 Why does a person have psychological problems? Who or what is to be blamed for the cause of an individual's psychological problems?

3.4 How do people in your community perceive someone who has a mental illness?

3.4.1 How are they treated in the community? Without giving names, can you provide an example?

3.5 According to your culture, who is believed to be affected the most by mental illness? Males, females, children, elderly, or people with disabilities, and what age?

State and explain.

4. What different methods are used to help people with mental illness within your culture?

- 4.1 Do you have knowledge regarding the non-traditional interventions for mental illnesses? If yes, are there any psychologists and social workers in your community?
- 4.2 Are the people in your culture open to using their services?
- 4.3 Do you know of any traditional healers within your community? If yes, could you provide the type of interventions they use or services they provide to help mentally ill people?
- 4.4 What have I not asked about, with respect to mental illness in your culture, that you think I should know about?

Appendix D: Questionnaire

Socio-demographic questionnaire

Thank you for taking the time to complete this questionnaire. Please use an (X) where appropriate to complete this questionnaire.

1. Please specify your gender:

Man
:

Woman:

Transgender, Male-to-Female (MTF):

Transgender, Female-to-Male (FTM):

Transgender, do not identify as man or woman:

Not sure:

Decline to state:

2. Age: _____

3. Please state which Ovaherero cultural group you belong to: _____

4. Please specify your religion:

Protestant:

Lutheran
:

Seventh-day Adventist:

Roman Catholic:

Non-Christian:

Unaffiliated:

Animism:

5. Please specify what languages you are fluent in speaking:

Otjiherero:

English:

Other language: _____

6. Please specify which languages you understand:

Otjiherero:

English:

Other language: _____

7. Highest educational qualification completed:

Primary:

Secondary:

University:

post-graduate:

No education obtained:

8. What type of dwelling do you live in?

Traditional dwelling:

Brick:

Shack:

Thatch:

Other: _____

9. Do you live by yourself?

Yes No

10. Do you live with family?

Yes No

11. Do you have any children?

Yes No

12. If you do, how many children do you have? _____ 13. How many children live with you? _____ 14. Do you have a television in your home?

Yes No

15. Does your house have electricity?

Yes No

16. Does your house have running water?

Yes No

17. How many livestock does your family/household own? _____

18. Please state what these livestock are: _____

Appendix E: Participant Pseudonyms

PARTICIPANT PSEUDONYMS

- 1. Abby***
- 2. Ben***
- 3. Clara***
- 4. Dan***
- 5. Ethan***
- 6. Fred***
- 7. Gale***
- 8. Helen***
- 9. India***
- 10. Jason***
- 11. Kay***
- 12. Larry***
- 13. Matthew***
- 14. Norris***
- 15. Ollie***

