INFLUENCE OF CULTURAL DEFINITIONS ON STIGMATIZATION OF MENTAL ILLNESS AMONG THE AWORIS OF LAGOS STATE, NIGERIA

(FUWJSS)
Volume5 Number 1
March, 2026

Ogundare Ghaffar Opeyemi,
Raji Sakiru Olarotimi,
Ibrahim Sodiq Olanrewaju,
Martins Yunus Oriyomi,
Abdullateef Halimah Bolanle
Department of Sociology, Lagos State University, Ojo, Lagos State, Nigeria. Email: ghaffar.ogundare@lasu.edu.ng

Abstract

This qualitative study investigates the influence of cultural definitions on the stigmatization of mental illness among the Aworis of Lagos State, Nigeria. Through semi-structured interviews with 35 purposively selected indigenes, community leaders, traditional healers, and caregivers in Iba LCDA, the research explores local perceptions, etiological beliefs, and treatment pathways for conditions like depression and bipolar disorder. Findings reveal a culturally constructed model of mental health, characterized by a strong reliance on indigenous diagnostic labels, the attribution of illness to spiritual causes or moral failings, and the preference for traditional and religious healing systems over biomedical psychiatry. Depression is understood as a situational emotional burden, while bipolar disorder is subsumed under the undifferentiated category of "madness." These cultural definitions actively fuel stigma, social exclusion, and delayed help-seeking. The study also documents pragmatic syncretism, where communities blend spiritual, herbal, and modern treatments. The study concludes that stigmatization of mental illness among the Aworis is deeply rooted in cultural meanings and explanatory models. It recommends culturally sensitive mental health interventions that integrate community leaders, traditional practitioners, and religious institutions to promote accurate understanding, reduce stigma, and improve access to appropriate mental health care.

Keywords: Culture, Mental Illness, Awori, Indigenous Healing, Spiritual Aetiology

Introduction

Language is a fundamental filter through which different social groups perceive and articulate diverse conditions of the society with a considerable influence on how mental illnesses are perceived and addressed worldwide, as it is a potent catalyst of the ensuing adoption of an unfavourable or stigmatizing language to describe particular mental

health conditions and circumstances in a particular context (Syed & Jacob, 2024; Volkow et al., 2021). The cultural impact on the concept of presenting mental health symptoms is a major factor and determinant of how individuals of different backgrounds present their distress in acceptable terms and in line with the norms and expectations of their cultures (Chambers et al., 2024; Jimenez et al., 2022; Lyons et al., 2025).

It commonly occurs in the form of a cultural bias towards giving priority to somatic symptoms over overtly recognizing mental health issues that can be stigmatized or less publicly discussed. The dissimilarity in symptom expression among the cultures highlights the extreme importance of being culturally sensitive in the analysis of the mental state of an individual. Clinicians can face patients who do not seem to be distressed at all but are, in fact, going through a lot of emotional distress that is not so obvious (Adebayo et al., 2024; Fogel et al., 2019; Thacore & Dharwadkar, 2024). This tendency indicates that emotional symptoms are not always denied but are expressed in culturally approved modes, which prevents the development of stigma.

This perspective, which assumes that cultural differences significantly shape the perception and representation of mental health symptoms, works against the idea that mental health has a universal interpretation. It instead argues that mental health symptoms are entrenched in the cultural milieu of an individual's life (Adebayo et al., 2024; Gureje et al., 2020). For example, signs of sadness or anxiety can vary across cultures; what one culture perceives as a physical condition, another may regard as a psychological disorder (Adebayo et al., 2024; Tomicic & Gjorgjioska, 2024). This also creates an idiom of distress, the culturally specific manifestations of suffering that offer not only common and shared experiences and ways of conceptualizing social suffering but also do not necessarily involve the identification of particular symptoms or syndromes. Such phrases as thinking too much or explaining feelings based on the heart and not the head are also common in a variety of African contexts and potentially a great avenue to discuss mental distress (Sweetland et al., 2013). They are also able to capture the continuity of social and moral status of a person even when he or she becomes ill and reduce stigma (Adeponle et al., 2017). The word kufungisisa in South Africa and Zambia, that is, refers to both physical/spiritual distress and mental distress (Fabian et al., 2018). The diverse manifestations of distress, especially behavioural or somatic in African settings (Sweetland et al., 2013), reflect the inability to use a set of Western diagnostic instruments universally, as they might not cover these culturally particular manifestations or culture-specific syndromes (Greene et al., 2021; M.C et al., 2021).

Definitions and meanings of mental disorders are often and inevitably tied to the cultural settings where they arise, and as a result, the symptomatology of culture-bound syndromes seems to be specific to certain ethnic or cultural groups (Jesus et al., 2023; Teodoro and Afonso, 2020). Culture-bound syndromes, unlike more world-recognised mental illnesses, like schizophrenia or depression, which share widely-similar symptoms across all cultures, are inherently influenced by the beliefs, practices, and social conventions of the communities within which they occur. These syndromes are inherently critical of the universality of psychopathic manifestation, preempting the ultimate importance of culture in its aetiology, experience, and manifestation (Adebayo et al., 2024; Gureje et al., 2020).

The studies in Nigeria and Zimbabwe indicate that not every symptom of mental disorders can be clearly connected with the biomedical categories; specifically, some of them, including the feelings of heat in the head, a bounding tongue, or crawling sensations are not directly linked to this category (Epidemiological Change and Chronic Disease in Sub-Saharan Africa: Social and Historical Perspectives, 2020). The cross-cultural replication or mindless adoption of the biomedical approach to mental health, which is based on a Western epistemic lens, has usually overshadowed the culturally-specific manifestations of distress (Mapaling & Naidu, 2023). This direction creates a threat of pathologizing the African experience of mental health and reducing the perception of African humanity to psychiatry and medicalization (Letsoalo et al., 2024). This kind of psychiatric imperialism through the economic and technological might of the West has been subjected to intense criticism for foisting Western ideas of psychopathology on non-Western people. Local expressions of distress and native knowledge play a critical role in informing the design of culturally attuned training, research, and services (Summerfield, 2020; Wondimagegn et al., 2023).

The cultural implications of illness have extensive implications on the way people think about and approach their health. Such meanings define the motivation to seek treatment, how to cope with the symptoms, and the level of support that is offered by family and community (Labinjo et al., 2020; Nwedu & Ominyi, 2025). Indicatively, in societies in which mental illness is strongly stigmatized, these people might be reluctant to acquire professional help due to the fear of being ostracized or humiliated by social circles. Most Nigerian communities often tend to conceptualize mental illness as a spiritual curse, the cause of witchcraft, a moral lapse, or personal weakness (Jidong et al., 2021; Labinjo et al., 2020; Nwedu & Ominyi, 2025; Pederson et al., 2020). The Nigerian mental illness is especially driven by the perceived hazards surrounding individuals with

mental illness, the spiritual perspective of causation, and the social distance that people wish to be associated with them (Ogunwale et al., 2023).

This stigma is not only a significant contributor to the aggravation of emotional distress but also a strong obstacle to seeking care (Nwedu and Ominyi, 2025). A study on Lagos, Nigeria, reports that perceived stigmatization may impact the help-seeking behaviours of psychiatric outpatients about mental health (Ogueji et al., 2020). As such, the mentally ill people in Lagos usually choose to get assistance from different sources before they finally find their way to professional mental health care. The trend reflects a more general problem in Nigeria, where there is a significant level of both external and internalized stigmatization of mental illnesses (Ogunwale et al., 2023).

A major ethnic group in southwestern Nigeria, such as the Aworis of Lagos State, is the Yoruba, whose worldview is usually built around an ongoing struggle of good and evil (Office, 2007; Olugbile et al., 2009). The adversity of illness is often ascribed to the evilness of enemies using metaphysical methods, and the solution is often to apply a metaphysical cure, directly or in conjunction with Western medicine. This rule is reported to apply to mental illness more than any other illness (Olugbile et al., 2009). Research done in Lagos establishes that the Yoruba worldview plays a key role in the perception and treatment of psychotic illness. The general attitude towards mental illness held by a large percentage of the population in this area is complex and includes both spiritual etiology, biomedical etiology, and psychosocial etiology, which may lead to stigmatization (Ogunwale et al., 2023).

Such a multifaceted cognition results in the pluralistic type of help-seeking, which involves multiple methods without exclusive opposition to each other since different causal conditions are supposed to entail different but complementary treatments (Ogunwale et al., 2023). According to Yoruba traditional healers, there are special classifications of mental illness, such as *wèrè ìran* (hereditary mental illness), *wèrè àmutọ̀runwá* (mental illness at birth), and *wèrè àfiṣe* (supernaturally afflicted mental illness) (Oyewale, 2022). They are also able to differentiate between irewesi okan (blues or depression) and aisan ọpọlọ (brain disease or madness) (Adeponle et al., 2017). These indigenous forms of healing tended to be highly interconnected with religion and social life, and they were used long before the advent of psychiatric hospitals (Alabi, 2025). Most Nigerians, particularly in the Yoruba region, continue to use traditional healers to treat and diagnose mental illnesses, and in many cases, they do this because they believe that all mental derangements are metaphysical (Alabi, 2025; Oyewale, 2022).

The awareness of the significant use of culture in identifying mental illness in various societies eventually helped in the consideration of culture in the DSM-IV outline. This model was to be used to inform clinicians on how to incorporate cultural aspects into psychiatric assessments and ensure more culturally sensitive and relevant care is provided (Carraso et al., 2020; Dinos et al., 2017). Nevertheless, notwithstanding its good intentions, the DSM-IV Outline of Cultural Formulation was a flawed document with basic limitations to its practical application. It was not very clear in the way clinicians needed to collect and assimilate cultural information into assessments, and this was an especially difficult task for those with no prior experience of cultural evaluations. Moreover, its construction neglected such key elements as cultural identity and dynamics of the therapeutic relationship (Alavi et al., 2025; Faregh et al., 2019) and thus did not reflect the diverse array of local understanding and healing methods (Mapaling and Naidu, 2023). Western mental health models are normally imposed without considering the well-established local healthcare institutions that are guided by spiritual spaces and keen on understanding the lives and culture of the local individuals (Wondimagegn et al., 2023). This can be approached at the risk of making people unwilling to seek assistance in case of having mental health issues, where the conceptualization is Western-derived (Alemu et al., 2023). These troublesome classifications may also contain misogynistic terms or culturally insensitive categories, and therefore, there is a need to have ethical-political frameworks that pay attention to socio-cultural formations of reasoning to establish clinically relevant mental illness (Guerrero, 2021). This study then seeks to examine how some mental health issues, such as bipolar disorder and depression, are understood, culturally defined, and traditionally managed among the Aworis in Lagos

Theoretical Framework

Social Constructionism Theory by Peter Berger and Thomas Luckmann (1966)

Sociologists Peter L. Berger and Thomas Luckmann first established the notion of social constructionism in their 1966 book "The Social Construction of Reality". Berger and Luckman's theories were influenced by other intellectuals, including Karl Marx, Emile Durkheim, and George Herbert Mead. Mead's theory of symbolic interactionism, which holds that social interaction is responsible for identity formation, was especially significant. The idea contends that reality, as we know it, is not an intrinsic, objective fact that exists irrespective of human cognition. Instead, it is shaped and defined by the continuous interactions and social processes that take place within a community. Individuals, according to the notion,

do not see the world solely in terms of biological or objective variables; rather, they construct their perception of reality through communication, cultural practices, and shared meanings (Berger & Luckmann, 1967).

It was argued that our ideas about morality, gender roles, and even mental health are not generally fixed, but rather formed by the specific norms, beliefs, and values of the society in which we live. These shared meanings are reproduced through language, social institutions, and relationships, transforming what is essentially a communal agreement into an absolute fact. Over time, these socially constructed realities become established in everyday life and are accepted as "natural" or "normal," even though they are the result of certain cultural settings and historical developments (Vera, 2016).

According to social constructionism, reality, including concepts like mental illness, is not an objective truth that exists independently but is shaped by the cultural, social, and historical contexts in which people live. This means that what one culture perceives as a mental illness may differ significantly from another culture's understanding based on their shared meanings, beliefs, and social interactions. Many cultures view mental illness as a phenomenon impacted by spiritual, religious, or moral ideas rather than just a medical or biological ailment. For example, in some African or traditional civilizations, mental health issues like depression or schizophrenia may be viewed as demonic possession or divine punishment (Gureje et al, 2020; Gbamgbose et al, 2021; Bisi et al, 2022). The cultural narratives, religious beliefs, and traditional healing methods of the community all influence these perceptions.

Research Methodology

This study adopted a descriptive qualitative research design. The design was considered most appropriate because it enabled an in-depth exploration of the cultural perceptions of mental illness and how these perceptions shape stigmatization and intervention practices. The qualitative approach facilitated the collection of detailed narratives and non-verbal cues that reflected participants' lived experiences, social meanings, and community attitudes toward mental health. The research was conducted in Iba Local Council Development Area (LCDA), a subdivision of the Ojo Local Government Area in Lagos State, Nigeria. Iba LCDA is located in the southwestern part of Lagos and comprises a blend of urban and semi-urban communities, with residential, commercial, and educational settings. It is culturally significant as one of the traditional strongholds of the Awori people, who are among the earliest Yoruba settlers in Lagos.

The population of the study comprised purposively selected indigenes of Awori, specifically middle-aged and elderly individuals, as well as key community stakeholders involved in mental health discourse and care. These included religious leaders, traditional healers, community health workers, family members, and caregivers of individuals living with mental illness. A total of thirty-five (35) participants were selected using purposive sampling.

This non-probability technique allowed for the inclusion of respondents with specific experiences and knowledge relevant to the research objectives. The sample distribution is shown below:

Participant Category	**Number**	**Method of Data Collection**
Residents (over 10 years)	10	In-depth interviews
Elderly Awori indigenes (50 years and above)	10	In-depth interviews
Religious Leaders (Muslim, Christian, and Traditional)	5	In-depth interviews
Traditional healers	5	Key informant interviews
Family members and caregivers	5	Key informant interviews
Total	**35**	—

Inclusion and Exclusion Criteria

Inclusion Criteria	**Exclusion Criteria**
• Indigene of Awori • Aged over 30 years • Domiciled in the study area for not less than 10 years • Willingness to participate	• Non-indigene of Awori • Informed consent not given • Inexperience with Mental Illness

The primary data collection tool was a semi-structured interview guide. This instrument allowed flexibility for participants to express their experiences and perceptions freely while maintaining consistency across interviews. Data was collected through face-to-face semi-structured interviews with all participants. Each session provided a conversational yet focused atmosphere that encouraged openness and cultural authenticity. Interviews were conducted in Yoruba to ensure clarity and inclusivity. With informed consent, interviews were audio-recorded to ensure accuracy of responses. Additional field notes captured contextual observations, gestures, and non-verbal cues, enhancing the interpretive depth of the data.

The recorded interviews were transcribed verbatim and reviewed multiple times to ensure accuracy and familiarity with the data. A thematic analysis approach will then be used to identify patterns, meanings, and

recurring themes within participants' narratives. This process will involve coding the data, grouping similar ideas, and developing broader themes that capture how cultural norms, gender expectations, and family dynamics influence women's experiences. All participants received detailed information about the purpose of the study, their rights, and confidentiality measures. Written or oral informed consent was obtained before participation. Participants were assured of voluntary involvement and the right to withdraw at any stage without repercussions. To ensure confidentiality, pseudonyms were used in transcripts and reports, and all data, including audio recordings and field notes, were stored securely.

Findings and Discussions

The findings of the study were grouped into various themes, and they include the use of indigenous labels and local diagnostic terms, symptom recognition through observable social and behavioural signs, bipolar disorder not clearly distinguished from general madness, depression understood as emotional burden and situational distress, spiritual, supernatural, and substance abuse as major cause and preference for traditional and religious treatment pathways.

Strong Use of Indigenous Labels and Local Diagnostic Terms

The data reveal a prevalent reliance on indigenous terminology to identify and categorize mental health conditions within the Awori community. Respondents consistently indicated that clinical diagnoses are often replaced by local labels that serve as both descriptive markers and social categorizations. These terms range from general descriptors of "madness" to specific metaphorical phrases, frequently carrying significant stigma or spiritual connotations that bypass medical nuance.

> *"As far as I'm concerned, although I'm not from the field but from a layman's point of view, I think mental illness can be defined as somebody who has some sort of disorder in the brain... Doctors will be able to say exactly what it means, but to the layman, we say 'e leyi ni ode ori' this guy has something worrying him in the head, so that what we all call mental illness... Sometimes we say 'ODE ORI', sometimes we say 'ALAISAN', sometimes we say 'WERE', sometimes we say 'ENI TI KAN DE SI'."* (Indigene, Male, 70 years)

This reliance on indigenous labeling often results in a reductionist approach to mental health, where complex conditions are grouped under a single, often stigmatizing, umbrella. The term *Were* (madness) appears to function as a catch-all category that erases specific distinctions between different types of mental health disorders.

> *"The Awori people still believe that the best way to treat such thing is because they don't even know which one or the category of the mental illness once you have mental illness the next thing they will say is that 'Ó tí yà wèrèy' that he has run mad, they don't even want to know whether he is this or that but once they see you talking on your own misbehaving doing lots of things they believe that this one is not more in his right sense." (Indigene, Male, 61 years)*

Similarly, another respondent thought that:

> *"There are words used to refer to such people like 'eti aso odogba'; these words affect them a lot, making them stay away from people because whenever they are in gatherings, people use some words on them or even avoid them. Or they even say Oni gan gan gan or Alagana" (Indigene, Female, 39 years)*

Beyond general categorization, the community employs deeply metaphorical and often derogatory phrases to describe the lived experience of the mentally ill. These labels act as social markers that enforce isolation. Phrases such as *eti aso odogba* (referring to unequal lengths, implying imbalance) or *Alagono* are not merely descriptive but are weaponized to shame or ostracize affected individuals, reinforcing the subtheme of derogatory labeling as a mechanism of social control.

Symptom Recognition Through Observable Social and Behavioural Signs

The data indicate that the identification of mental illness among the Awori is heavily predicated on the observation of tangible deviations from social norms rather than introspective or clinical symptoms. Community members primarily assess mental health status through conversational coherence, detecting issues when an individual begins "talking off-topic" or displaying disjointed logic. This verbal disconnect is often the first indicator of a "sudden behavioral shift," where the inability to maintain a relevant line of conversation signals that the individual has lost touch with shared reality.

> *"The signs are many but the common ones that I can easily point out are that the person will have a kinda of abnormal behavior, even his speech will be different from the other way round. Assuming you are discussing about A, he may be talking about B so most of the times when you ask him or her questions the way he is going to answer you is different from your own views... You will nau be asking that what is wrong I am talking about A and you are talking of B…." (Male, 61yrs, Religious Leader)*

Beyond verbal incoherence, the community recognizes mental instability through "mood instability" and physical volatility, specifically "aggression and anger outbursts." Respondents described a cyclical nature to these symptoms, where an individual might appear socially competent one moment, only to experience a sudden onset of erratic behavior.

> *"It depends on the particular illness the victim is afflicted with... sometimes he is normal as a matter of fact sometimes he goes to the farm and talk to people in the community but when this illness get into his head he can take machete and start running around and shouting, but in fairness most of the times he is harmless but i usually tell people that when they see him with machete everyone should avoid eye contact with him because at the end of the day if there is an havoc all he will say is that he is not mentally stable. (Male,72yrs, Community Elder)*

Another commonly cited sign was wandering, talking alone, and general restlessness, which respondents associated with a loss of self-control and social awareness:

> *"The signs are many… he may just start running without anybody chasing him or talking alone." (Male, 53yrs, Religious Leader)*

This excerpt shows that purposeless movement and solitary speech are culturally recognized symptoms of mental illness. These behaviours visibly disrupt social norms and immediately draw community attention, making them powerful indicators of mental distress. Improper dressing and outward appearance were also mentioned as behavioural cues. One respondent explained that individuals with mental illness could be identified by a lack of coordination in dress and presentation:

> *"Such people… their dressing when they are going out they won't even look at it, the one on top is different from the one down." (Female, 61yrs, Indigene*)

Visual cues related to personal hygiene and "improper dressing" serve as definitive markers for recognizing mental health issues, particularly in women or those suffering from stress-induced breakdowns. The community closely monitors appearance as a proxy for internal order; thus, mismatched clothing or a lack of self-care is interpreted as a clear sign of a disorder requiring intervention.

Bipolar Disorder Not Clearly Distinguished

Findings reveal that, rather than the illness being understood as a specific mental health condition with identifiable patterns such as mood episodes, bipolar disorder is commonly subsumed under a broad cultural category of abnormality. This lack of diagnostic separation reflects limited

clinical awareness and a culturally grounded tendency to interpret mental illness through generalized behavioural labels. Several respondents explicitly noted that community members do not differentiate between types of mental health conditions. Instead, any form of unusual or disruptive behaviour is quickly categorized as madness:

> *"They don't even know which one or the category of the mental illness — once you have mental illness the next thing they will say is that 'Ó tí yà wèrèy'." (Male, 42yrs, Indigene)*

Because the community lacks a specific category for mood disorders, the "fluctuating sanity" typical of bipolar disorder is interpreted through a lens of unpredictability and spiritual affliction. The condition is not seen as a steady illness but as a force that "gets into the head" sporadically. This episodic misbehavior—where an individual shifts from functioning normally to aggression—validates the community's fear but fails to yield a specific diagnosis, leaving the individual socially isolated during both manic and depressive states.

> *"Sometimes he is normal as a matter of fact sometimes he goes to the farm and talk to people in the community but when this illness get into his head he can take machete and start running around and shouting, but in fairness most of the times he is harmless but i usually tell people that when they see him with machete everyone should avoid eye contact with him because at the end of the day if there is an havoc all he will say is that he is not mentally stable." (Male, 65yrs, Indigene)*

The difficulty in distinguishing bipolar disorder from general madness is further highlighted by the suddenness of the behavioral shifts. Community members express bewilderment when an apparently "normal" interaction instantly devolves into "misbehavior." This rapid cycling reinforces the perception of mental illness as an unstable, dangerous presence rather than a treatable condition. The lack of clear diagnostic separation means these "minor" or episodic illnesses are frequently misunderstood, leaving the community to rely on observation of immediate conduct rather than medical history.

> *"We have some people you will not even know that there is anything wrong with him because as at the time he way discussing with you he behave normally but just within two or three minutes, he will just misbehave so that one is not that the person has run mad but it is a kind of mental illness that have happen." (Male, 53yrs, Caregiver)*

Depression as Emotional Burden and Situational Distress

The data suggest that depression is rarely viewed as a standalone clinical pathology within the Awori community. Instead, it is deeply contextualized as a reaction to external stressors such as specifically

economic hardship, marital discord, or grief. The community primarily identifies this state not through mood per se, but through "absent-mindedness" or a disconnection from the immediate environment.

> *"Yes, there is a particular guy I was talking to him but it was like I was talking to a dummy for like 2-4 minutes I had to tap him before he came back to life and was like what was i saying and i have been talking for some minutes he had to apologize and i concluded he must be depressed Iater got to know from someome that he lost a close relative." (Male, 67yrs, Indigene)*

This absence of clinical distinction is reinforced by the language used to describe the condition. Terms like *irewesi okan* (weariness of the soul/mind) anchor the experience in the realm of emotional burden caused by tangible life struggles. Respondents explicitly linked this state to the "current situation" in Nigeria, suggesting that economic stress and the inability to achieve "positive results" in work are primary drivers. Consequently, the remedy is often framed around resolving the situational trigger, such as performing rituals to bring success, rather than addressing the psychological symptoms directly.

> *"Local term for depression 'irewesi okan' 'arokan'. They are always absent-minded during meetings or discussions. It could be cause by a situation, especially the [current] situation in Nigeria... 'Irewesi okan' usually occur when someone isn't seeing positive results in his or her work... " (Male, 70yrs, Community Elder)*

Other similar views opined that:

> *"Islamic perspective is that you need to study the person, know exactly what is going on within his surroundings maybe he is facing one problem or the other or maybe he is thinking of something that pressing him down that he cannot even discuss with anybody so that is why he is behaving abnormally." (Male, 60yrs, Religious Leader)*

The conceptualization of depression as "something pressing him down" highlights the somatic and cognitive weight of the condition. It is seen as an internal pressure created by unvoiced worries. For women in the community, depression is frequently tethered to domestic and marital instability. The data indicate that "misbehavior" or mental instability in women is often quickly attributed to marital problems, such as being sent out of the matrimonial home. Here, the "situational distress" is so central to the diagnosis that the community's intervention focuses on restoring the marriage to balance the individual's mental state, effectively treating the social circumstance as the pathology.

> *"Some people it may be due to martial problems we have some women whereby they are having martial issues in a case they have*

> *mental disorder… 'My husband just sent me out of the house up till now I have not been able to take care of myself'... " (Male, 70yrs, Community Elder)*

Another was of the view that:

> *"Within the community most of them can't distinguish depression and mental illness... They would rather think that it is something else because like I said they do not know the meaning of depression... Depression is completely different from mental illness though depression could lead to mental illness if not taken care of properly." (Indigene, Male, 61 years)*

The strong association with situational causes masks the reality of depression as the community looks for a tangible cause, like a death or a lost job, to chronic depression without an obvious trigger is often misunderstood or miscategorized. The inability to distinguish depression from general mental illness or madness unless a clear social cause is present highlights a significant gap in health literacy.

Spiritual, Supernatural, and Substance Abuse as Major Causes

The etiology of mental illness among the Awori is frequently located in the supernatural realm, where external spiritual forces supersede human agency. A prevalent belief is that mental instability is not merely biological but a result of malevolent spiritual interference, specifically witchcraft. This explanation serves as a primary "precautionary" framework, where abnormal behavior is interpreted as the visible manifestation of a spiritual attack or a curse, necessitating a shift from medical to traditional investigation.

> *"some people believe that once a person has a mental illness, maybe it's through witchcraft or you have done something that is not good and that is the precaution, and that is why the person is behaving like that... they will say oh the witchcraft is disturbing this so-so person and that is why he is behaving like this and talking like this." (Male, 61yrs, Traditional Practitioner)*

Conversely, a muslim cleric was of a differing opinion that:

> *"Yes I will like to say that culturally there are but as Muslim we don't believe in such things we believe in destiny which is what Allah has destined so other people might believe that in their family their fore-father has been similarly afflicted, so so person has been similarly afflicted also, there are so many beliefs but it depends on an individual faith." (Male, 63yrs, Religious Leader)*

While traditional beliefs emphasize witchcraft, the Islamic perspective within the community introduces the concept of "destiny" and divine will. Here, mental affliction is not necessarily the result of an enemy's curse but

may be predestination from Allah. This theological distinction allows some community members to reject the notion of malicious spirits in favor of accepting the condition as a divine test or familial trait. Alternatively, there are instances where mental illness is viewed as a direct consequence of ritual backlash, that is, a punitive spiritual outcome for seeking illicit wealth. In these narratives, the individual is not a passive victim of destiny but an active participant in their own downfall.

> *"There was a particular man that got afflicted with mental illness. When I got to know what happened, I heard he got himself involved with money ritual so it actually backfired. I was told there were three; I think the other two are dead, but he is still living, but not mentally balanced... From my perspective, that is the only information I can get." (Indigene, Male, 74 yrs)*

In parallel with supernatural explanations, the community heavily blames modern substance abuse for the rising rates of mental illness, particularly among the youth. This youth moral decline narrative posits that drug abuse is the primary catalyst for madness, driven by peer pressure and moving with bad gangs. Religious and community leaders actively use this link to campaign for morality, framing mental health issues as a preventable consequence of social deviance rather than a random medical occurrence.

> *"it is caused by taking harmful substances like 'igbo' Indian hemp. 'Irewesi okan' usually occur when someone isn't seeing positive results in his or her work... for self-affliction like smoking, some rituals can be done such individual to abstain from it." (Female/63yrs/Community Elder)*

Similarly, another interviewee espouses the role of religious leaders on the menace:

> *"Yes, I think the religious leaders have been talking on drugs abuse because drugs abuse has been responsible for most of this mental illness so the religious leaders has been sanitizing the community from time to time that they should caution and make sure their wards are free from this drugs abuse, which might result from moving with bad gangs." (Indigene, Female, 48 yrs)*

Preference for Traditional and Religious Treatment Pathways

The data strongly suggests that the Awori community retains a deep-seated preference for traditional and religious healing modalities over Western medicine, particularly for mental health issues, which are often viewed as having spiritual roots. Respondents indicated that the community frequently bypasses hospitals in favor of traditional healers (Babalawos) or religious leaders, driven by the belief that medical doctors

cannot treat the spiritual origins of madness and the use of herbal remedies (agbo, concoctions) are believed to have calming and curative properties.

> *"So the next thing is they will take that person, there is a tradition way of treating such person even we have here in iba whereby they have herbs which they normally use the one that is meant to drink, the one that is meant to bath with, the one that they are going to use to rub his or her body and within a particular short of time to God be the glory the sickness will go and the person will come to order." (Male, 61yrs, Religious Leader)*

Similarly, another added that:

> *".....they think less of medical treatment but more of traditional and cultural treatments because here they talk about thing like 'wo san ni ata' (he was shot by evil), I have never heard of such until I got to this place and they will be like don't take such person to an hospital even someone that has malaria you will hear them say they should not take such person to an hospital so that is to show their level of backwardness in terms of modern and medical treatment." (Female, 42yrs, Resident)*

When traditional pathways are chosen, the treatment often involves specific ritualistic appeasements aimed at pacifying malevolent forces. These rituals, known locally as *ipese* or *ebo*, are considered essential prerequisites for healing, reinforcing the cultural narrative that mental illness is a transaction between the human and spirit worlds that requires payment or sacrifice to resolve.

> *"Yes like I said they offer a lot of appeasement they call it 'ipese' to they gods... they usually attach a lot of traditional folktale, baseless stories... somebody will say until you do sacrifice this things can never be cured or healed until you appease the gods, take 'ebo to ori ta' () this illness can never be cured... the other options that they have which is tht medical treatment they wnt make use it." (Male, 67yrs, Traditional Healer)*

In parallel to traditional rituals, Islamic spiritual healing, specifically *Rukya* (recitation of the Quran), plays a pivotal role. The community seamlessly integrates religious doctrine with therapeutic practice, viewing the Quran not just as a holy text but as a medical instrument capable of neutralizing the "Jinn" or spirit disturbing the individual.

> *"When we look at the Quran there is what we call Rukya... so there is a specific aspect of the Quran and prayer that the prophet recommends like that one I told you when he came to the mosque, we did rukya for that man and for the glory of Allah he was able to heal up and he is doing fine now." (Male, 71yrs, Islamic Cleric)*

The intervention is not merely prayer-based but involves a structured counseling process where the leader uses scripture to call the person to order, effectively replacing clinical therapy with pastoral care that addresses the moral and emotional dimensions of the crisis.

> *"There is a process we call the counseling process… you call him, you counsel him, quote the ideas of the prophet, and the person will explain what is happening." (Male, 61yrs, Religious Leader)*

Interestingly, the rigid dichotomy between traditional and modern medicine is beginning to blur. The community increasingly views the matching of both systems as the optimal approach. In this syncretic model, an individual might undergo *Rukya* to address the spiritual component and simultaneously consume traditional herbs for physical restoration, suggesting a pragmatic approach to healing. There is also evidence of modernized traditional practice increasing acceptance, where traditional healers adopt elements of biomedical practice,

> *"So we have Islamic way of treating such and we have the traditional way but here in the community we match the two together like that boy I told you about after doing the rukia the father still asked him to go and see the traditional side of it the man provided agbo (herbs) for him and he used it and he is able to heal up and today he is not having that issue again." (Male, 71yrs, Islamic Cleric)*

Similarly, another resident added that:

> *"don't be surprised I saw a traditional healer using stethoscope on a patient I asked them and I was told they have been trained to use it so this has gone a long way in the traditional healers, they are some things that government will incorporate and they will modernize it we have started seeing traditional medicine in form of tablets and syrup all this are modernization" (Male,72yrs, Community Elder)*

Discussion

The study's findings revealed a strong use of indigenous labels and local diagnostic terms, which directly corroborates literature emphasizing culture as a fundamental filter for illness perception (Syed & Jacob, 2024). Terms like *"were"* (mad person), *"ode ori"* (something in the head), and *"eni ti kan de si"* (someone something has happened to) function not merely as descriptors but as culturally sanctioned diagnostic categories that carry specific etiological assumptions and social consequences. This aligns with global observations that language powerfully catalyzes stigma (Volkow et al., 2021) and is particularly potent in contexts where mental illness is spiritualized (Jidong et al., 2021). The collapsing of diverse conditions like bipolar disorder into the catch-all category of *"were"* exemplifies the "lack of clear diagnostic separation" noted in

the findings. This practice confirms Oyewale's (2022) documentation of indigenous Yoruba classifications (e.g., *wèrè àfiṣe* for supernatural affliction) while simultaneously revealing a lay simplification that erases clinical nuance. This lexical reduction fuels stigma by associating all mental distress with the most severe, frightening, and socially disruptive behavioural archetype, reinforcing social distance and fear (Ogunwale et al., 2023).

The attribution of mental illness to spiritual, supernatural causes and substance abuse is a cornerstone of the study's explanatory model, deeply rooted in the Yoruba worldview of a cosmos animated by spiritual forces and moral balance (Olugbile et al., 2009).

The findings that mental illness is ascribed to witchcraft (*àjẹ*), spirit possession, or ritual backlash (*"money ritual... backfired"*) are consistent with extensive Nigerian literature (Labinjo et al., 2020; Nwedu & Ominyi, 2025). These attributions have profound implications for stigma. Framing illness as a spiritual attack or a consequence of moral transgression (e.g., seeking illicit wealth) transforms the afflicted individual from a patient into a victim of supernatural malice or a perpetrator of moral failing. As noted in the literature, such beliefs significantly increase desired social distance (Ogunwale et al., 2023). Concurrently, the heavy blame placed on substance abuse, particularly Indian hemp (*igbo*), and its linkage to a youth moral decline narrative reflects a modern, yet still moralistic, causal model. This echoes findings where drug abuse is framed as a voluntary deviance leading to madness, allowing communities to attribute responsibility to the individual and their family for poor upbringing (Jidong et al., 2021).

The conceptualization of depression as an emotional burden and situational distress, recognized through *"absent-mindedness"* and linked to hardship, aligns with the documented use of "idioms of distress" in African settings (Sweetland et al., 2013). Terms like *"irewesi okan"* (weariness of the heart/mind) and *"arokan"* (constant thinking) somaticize and contextualize psychological pain, anchoring it in social realities like economic stress or grief. This finding supports Adeponle et al.'s (2017) work on how local expressions can capture the social and moral continuity of the person. However, the critical implication of this model is that it obscures depression as a clinical condition. When distress is seen solely as a natural reaction to circumstance (e.g., "the current situation in Nigeria"), its persistence beyond the situational trigger or its occurrence without an obvious cause becomes inexplicable, often re-categorized as *"were"* This creates a major gap in help-seeking, as chronic, endogenous depression may not be recognized as requiring specific intervention until it manifests in severe behavioural disruption.

The community's focus on resolving the social trigger (e.g., marital mediation), while supportive, may neglect the underlying neuropsychiatric condition, delaying effective biomedical or psychotherapeutic treatment.

The failure to distinguish bipolar disorder from general madness presents a significant clinical and social challenge. The community's recognition of "fluctuating sanity" and "episodic misbehavior" accurately captures the cyclical nature of the disorder but interprets it through a spiritual or moral lens rather than a medical one. This finding extends the literature on culture-bound syndromes by showing how a globally recognized medical condition is absorbed into a pre-existing, spiritually framed category of "madness" (Jesus et al., 2023). The consequence is that individuals with bipolar disorder are subjected to the same stigmatizing labels, social isolation, and potentially harmful traditional treatments (e.g., harsh physical restraint or aggressive spiritual cleansing) as those with psychotic disorders. Their specific need for mood stabilizers and targeted psychotherapy is overlooked, as the treatment goal becomes expelling "madness" rather than managing a mood disorder. This erasure exemplifies the "cross-cultural adoption of the biomedical approach" being overshadowed by local manifestations, as warned by Mapaling & Naidu (2023).

The marked preference for traditional and religious treatment pathways, including herbs such as (*agbo*), ritual appeasement (*ebo, ipese*), and Islamic *Rukya*, is a rational choice within the community. If the cause is spiritual, the cure must be spiritual. This validates the literature on the Yoruba pluralistic help-seeking model, where different causalities demand complementary treatments (Ogunwale et al., 2023). The high cultural legitimacy of traditional healers and religious leaders, contrasted with the perceived ineffectiveness of hospitals for *"spiritual problems,"* explains the bypassing of biomedical systems noted in Lagos studies (Ogueji et al., 2020). The findings on syncretic practices (e.g., combining *Rukya* with herbs) and the modernization of traditional healing (e.g., healers using stethoscopes, packaged herbs) are particularly significant. They reveal a dynamic, adaptive indigenous system, challenging notions of traditional medicine as static. This convergence of systems, when collaborative, could form the basis for culturally tailored interventions that bridge gaps, as suggested by models for involving traditional healers (Wondimagegn et al., 2023).

Conclusion and Recommendations

This study elucidates how the Awori cultural framework, through its lexicon, spiritual etiology, and behavioural symptom recognition, actively constructs the reality of mental illness in ways that profoundly shape lived

experience, stigma, and healing journeys. It requires a culturally literate praxis that respects indigenous knowledge systems while gently expanding their repertoire to include biomedical concepts, ultimately forging a hybrid pathway to care that is both scientifically sound and culturally legitimate. The goal is not to eradicate the cultural worldview but to work within its logic to reduce harm, alleviate suffering, and open avenues for social inclusion and effective treatment for all members of the community. The study recommends integrating indigenous labels and spiritual concepts into clinical diagnostic frameworks to enhance cultural competence and patient trust. Policy efforts should formalize the existing syncretic care model by training traditional healers and religious leaders to recognize acute clinical symptoms and facilitate referrals, effectively bridging the gap between spiritual and biomedical systems.

References

Adebayo, Y. O., Adesiyan, R. E., Amadi, C. S., Ipede, O., Karakitie, L. O., & Adebayo, K. T. (2024). Cross-cultural perspectives on mental health: Understanding variations and promoting cultural competence. *World Journal of Advanced Research and Reviews*, 23(1), 432. https://doi.org/10.30574/wjarr.2024.23.1.2040

Adeponle, A., Groleau, D., Kola, L., Kirmayer, L. J., & Gureje, O. (2017). Perinatal depression in Nigeria: perspectives of women, family caregivers and health care providers. *International Journal of Mental Health Systems, 11(1*). https://doi.org/10.1186/s13033-017-0134-6

Adjei-Banuah, N. Y., Reichenberger, V., Ayiku, R. N. B., Bondzie, E. P. K., Amarteyfio, K. N. A. A., Agyekum, M. P., Mirzoev, T., Murphy, A., Ohene, S., Antwi, E., & Agyepong, I. A. (2024). Factors influencing primary care access for common mental health conditions among adults in West Africa: A scoping review [Review of Factors influencing primary care access for common mental health conditions among adults in West Africa: *A scoping review]. Research Square (Research Square). Research Square* (United States). https://doi.org/10.21203/rs.3.rs-4874948/v1

Aghukwa, C. N. (2012). Care Seeking and Beliefs About the Cause of Mental Illness Among Nigerian Psychiatric Patients and Their Families. *Psychiatric Services*, 63(6), 616. https://doi.org/10.1176/appi.ps.201000343

Alabi, T. O. (2025). Entangled pathways: navigating mental healthcare dynamics in Abeokuta. *Discover Mental Health*, 5(1), 133. https://doi.org/10.1007/s44192-025-00264-9

Alavi, M., Lagadec, D. L., & Cleary, M. (2025). Challenges of Cross-Cultural Validation of Clinical Assessment Measures: *A Practical Introduction. Journal of Advanced Nursing*, 82(1), 941. https://doi.org/10.1111/jan.16906

Alemu, R. E. G., Osborn, T. L., & Wasanga, C. (2023). The network approach: A path to decolonize mental health care. *Frontiers in Public Health*, 11, 1052077. https://doi.org/10.3389/fpubh.2023.105207

Carrera, L. C., Lévesque-Daniel, S., Radjack, R., Moro, M. R., & Lachal, J. (2020). Clinical Approaches to Cultural Diversity in Mental Health Care and Specificities of French Transcultural Consultations: A Scoping Review [Review of *Clinical Approaches to Cultural Diversity in Mental Health Care and Specificities of French Transcultural Consultations: A Scoping Review]. Frontiers in Psychiatry,* 11. Frontiers Media. https://doi.org/10.3389/fpsyt.2020.579147

Chambers, M., Välimäki, M., Gronholm, P. C., & Soliman, A. (2024). Editorial: Cultural considerations in relation to mental health stigma. *Frontiers in Psychiatry*, 15, 1434319. https://doi.org/10.3389/fpsyt.2024.1434319

Dinos, S., Ascoli, M., Owiti, J. A., & Bhui, K. (2017). Assessing explanatory models and health beliefs: An essential but overlooked competency for clinicians. *BJPsych Advances*, 23(2), 106. https://doi.org/10.1192/apt.bp.114.013680

Epidemiological Change and Chronic Disease in Sub-Saharan Africa:Social and historical perspectives. (2020). https://doi.org/10.14324/111.9781787357044

Fabian, K. E., Fannoh, J., Washington, G. G., Geninyan, W. B., Nyachienga, B., Cyrus, G., Hallowanger, J. N., Beste, J., Rao, D., & Wagenaar, B. H. (2018). "My Heart Die in Me": Idioms of Distress and the Development of a Screening Tool for Mental Suffering in Southeast Liberia. *Culture Medicine and Psychiatry*, 42(3), 684. https://doi.org/10.1007/s11013-018-9581-z

Faregh, N., Lencucha, R., Ventevogel, P., Dubale, B. W., & Kirmayer, L. J. (2019). Considering culture, context and community in mhGAP implementation and training: challenges and recommendations from the field [Review of Considering culture, context and community in mhGAP implementation and training: challenges and recommendations from the field]. International *Journal of Mental Health Systems*, 13(1). BioMed Central. https://doi.org/10.1186/s13033-019-0312-9

Fogel, A., Nazir, S., Hirapara, K., & Ray, S. (2019). Cultural Assessment And Treatment Of Psychiatric Patients. *StatPearls.* https://pubmed.ncbi.nlm.nih.gov/29493936/

Greene, M. C., Yangchen, T., Lehner, T., Sullivan, P. F., Pato, C. N., McIntosh, A. M., Walters, J., Gouveia, L., Msefula, C., Fumo, W., Sheikh, T. L., Stockton, M. A., Wainberg, M. L., & Weissman, M. M. (2021). The epidemiology of psychiatric disorders in Africa: a scoping review [Review of The epidemiology of psychiatric disorders in Africa: a scoping review]. *The Lancet Psychiatry*, 8(8), 717. Elsevier BV. https://doi.org/10.1016/s2215-0366(21)00009-2

Guerrero, E. G. (2021). Effective Elimination of Structural Racism. In IntechOpen eBooks. IntechOpen. https://doi.org/10.5772/intechopen.95223

Gureje, O., Lewis-Fernandéz, R., Hall, B. J., & Reed, G. M. (2020, January 27). Cultural considerations in the classification of mental disorders: why and how in ICD-11. *In BMC Medicine* (Vol. 18, Issue 1, p. 25). BioMed Central. https://doi.org/10.1186/s12916-020-1493-4

Jesus, S., Costa, A. R., Simões, G., Gomes, A. I., Tarelho, A., & Garrido, P. (2023). Psychopathology without Borders: Transcultural psychiatry and implications in clinical presentation and practice. *European Psychiatry*, 66. https://doi.org/10.1192/j.eurpsy.2023.1742

Jidong, D. E., Bailey, D., Sodi, T., Gibson, L., Sawadogo, N., Ikhile, D., Musoke, D., Madhombiro, M., & Mbah, M. F. (2021). Nigerian cultural beliefs about mental health conditions and traditional healing: a qualitative study. *The Journal of Mental Health Training Education and Practice,* 16(4), 285. https://doi.org/10.1108/jmhtep-08-2020-0057

Jimenez, D. E., Park, M., Rosen, D., Joo, J. H., Garza, D. M., Weinstein, E. R., Conner, K. O., Silva, C., & Okereke, O. I. (2022). Centering Culture in Mental Health: Differences in Diagnosis, Treatment, and Access to Care Among Older People of Color [Review of 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. Elsevier BV. https://doi.org/10.1016/j.jagp.2022.07.001

Labinjo, T., Serrant, L., Ashmore, R., & Turner, J. (2020). Perceptions, attitudes and cultural understandings of mental health in Nigeria: a scoping review of published literature [Review of Perceptions, attitudes and cultural understandings of mental health in Nigeria: a scoping review of published literature]. *Mental Health Religion & Culture*, 23(7), 606. Taylor & Francis. https://doi.org/10.1080/13674676.2020.1726883

Letsoalo, D. L., Ally, Y., Tsabedze, W. F., & Mapaling, C. (2024). Challenging the nexus: Integrating Western psychology and African cultural beliefs in South African mental health care. *Psychology in Society*, 66(2). https://doi.org/10.57157/pins2024vol66iss2a6320

Lyons, P., Edwardes, A., Bladon, L., & Abel, K. M. (2025). Culturally sensitive mental health research: a scoping review [Review of Culturally sensitive mental health research: a scoping review]. *BMC Psychiatry*, 25(1), 190. BioMed Central. https://doi.org/10.1186/s12888-025-06575-z

Mapaling, C., & Naidu, T. (2023). Reflexivity on medicalisation of the mind and the biomedical invasion on being human. *Psychology in Society*, 65(1). https://doi.org/10.57157/pins2023vol65iss1a5817

M.C, G., Yangchen, T., Lehner, T., P.F, S., C.N, P., McIntosh, A. M., Walters, J., L.C, G., C.L, M., Fumo, W., T.L, S., M.A, S., M.L, W., & M.M, W. (2021). The epidemiology of psychiatric disorders in Africa: a scoping review [Review of *The epidemiology of psychiatric disorders in Africa: a scoping review]. Carolina Digital Repository (University of North Carolina at Chapel Hill)*. University of North Carolina at Chapel Hill. https://doi.org/10.17615/xjhq-mh19

Nwedu, A., & Ominyi, J. (2025). Adapting to Stigma, Resilience and Systemic Barriers: Lived Experiences of Adolescents and Young Adults With Mental Illness. *Mental Illness*, 2025(1). https://doi.org/10.1155/mij/5522798

Office, E. (2007). 10th International Conference on Philosophy, Psychiatry and Psychology, Sun City. *South African Journal of Psychiatry*, 13(3), 20. https://doi.org/10.4102/sajpsychiatry.v13i3.23

Ogueji, I. A., Ojo, T. E., & Gidado, T. N. (2020). Perceived Stigmatization, Sociodemographic Factors, And Mental Health Help-Seeking Behaviors Among Psychiatric Outpatients Attending A Psychiatric Hospital In Lagos, Nigeria. medRxiv (*Cold Spring Harbor Laboratory).* https://doi.org/10.1101/2020.11.10.20229120

Ogunwale, A., Fadipe, B., & Bífárìn, O. (2023). Indigenous mental healthcare and human rights abuses in Nigeria: The role of cultural syntonicity and stigmatization [Review of Indigenous mental healthcare and human rights abuses in Nigeria: The role of cultural syntonicity and stigmatization]. *Frontiers in Public Health*, 11, 1122396. Frontiers Media. https://doi.org/10.3389/fpubh.2023.1122396

Okafor, I. P., Oyewale, D. V., Ohazurike, C., & Ogunyemi, A. (2022). Role of traditional beliefs in the knowledge and perceptions of mental health and illness amongst rural-dwelling women in western Nigeria. African Journal of Primary Health Care & Family Medicine, 14(1). https://doi.org/10.4102/phcfm.v14i1.3547

Olugbile, O., Zachariah, M., Kuyinu, A., Coker, A. L., Ojo, O., & Isichei, B. (2009). Yoruba World View and the nature of Psychotic Illness. *African Journal of Psychiatry*, 12(2), 149. https://doi.org/10.4314/ajpsy.v12i2.43733

Oyewale, A. S. (2022). A Translation and Literary Analysis of Adebayo Faleti's Poem: Ojo Ilayefun". *Yoruba Studies Review*, 7(1), 1. https://doi.org/10.32473/ysr.v7i1.131451

Pederson, A. B., Burnett-Zeigler, I., Fokuo, J. K., Wisner, K. L., Zumpf, K., & Oshodi, Y. (2020). Mental health stigma among university health care students in Nigeria: a cross-sectional observational study. *Pan African Medical Journal*, 37, 5. https://doi.org/10.11604/pamj.2020.37.5.24898

Summerfield, D. (2020). What kind of in-patient psychiatry for Africa? Report from Zimbabwe. *The British Journal of Psychiatry*, 217(3), 467. https://doi.org/10.1192/bjp.2019.270

Sweetland, A. C., Belkin, G. S., & Verdeli, H. (2013). Measuring depression and anxiety in sub-saharan africa [review of measuring depression and anxiety in sub-saharan africa]. *Depression and Anxiety*, 31(3), 223. Wiley. https://doi.org/10.1002/da.22142

Syed, A., & Jacob, M. (2024). Languaging psychopathology: neurobiology and metaphor [Review of Languaging psychopathology: neurobiology and metaphor]. *Frontiers in Psychiatry*, 15. Frontiers Media. https://doi.org/10.3389/fpsyt.2024.1320771

Teodoro, T., & Afonso, P. (2020). Culture-Bound Syndromes and Cultural Concepts of Distress in Psychiatry. *Revista Portuguesa de Psiquiatria e Saúde Mental*, 6(3), 118. https://doi.org/10.51338/rppsm.2020.v6.i3.139

Thacore, V. R., & Dharwadkar, N. P. (2024). Diagnosing mental disorders in diverse cultures. *Journal of Indira Gandhi Institute Of Medical Sciences*, 10(1), 6. https://doi.org/10.4103/jigims.jigims_44_23

Tomičić, A., & Gjorgjioska, M. A. (2024). Epistemic inequality in the digital era: Unpacking biases in digital mental health. *Theory & Psychology*. https://doi.org/10.1177/09593543241279131

Volkow, N. D., Gordon, J. A., & Koob, G. F. (2021). Choosing appropriate language to reduce the stigma around mental illness and substance use disorders. *Neuropsychopharmacology,* 46(13), 2230. https://doi.org/10.1038/s41386-021-01069-4

Wondimagegn, D., Pain, C., Seifu, N., Cartmill, C., Alemu, A. A., & Whitehead, C. (2023). Reimagining global mental health in Africa [Review of Reimagining global mental health in Africa]. *BMJ Global Health*, 8(9). BMJ. https://doi.org/10.1136/bmjgh-2023-013232.