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Cultural Adaptation Practices in Health Seeking Behaviour by Caregivers of Mentally Ill Patients in Uasin Gishu County, Kenya

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Abstract

For the mentally ill, cultural prescriptions and proscriptions play a major role in their caregiver's health-seeking behaviour. Most ill patients seek treatment in hospital setting but still, culturally adaptive options are left open for further exploration. This study sought to determine cultural adaptation intervention in health seeking behaviour by caregivers of people with mental illness in Uasin Gishu County, Kenya. The study adopted the concurrent mixed methods design that integrated both the qualitative and quantitative approaches. The study was anchored on the constructivism theory and the health-seeking behaviour theory. The target population was caregivers of people with mental illness drawn from Uasin Gishu County and health care service providers in the mental unit of the Moi Teaching and Referral Hospital (MTRH). A sample of 487 caregivers of people with mental illness was selected purposively, while a census was conducted to identify 18 health care providers. Structured questionnaires and focus group discussions were used to gather data from caregivers. Data from healthcare providers were collected using interviews. Quantitative data were analyzed using descriptive and inferential statistics, while qualitative data were analyzed thematically. However, cultural adaptation intervention positively and significantly affected health-seeking behaviour ($b = 0.452$, $p < 0.05$). The study revealed that negative constructions of mental illness have enhanced the use of adaptive cultural interventions among caregivers. This study contributes to the existing discourse on mental illness by leveraging the cultural role in health-seeking behaviour. The study recommends that caregivers of people with mental illness seek to exploit cultural adaptive factors to intervene in the relationships involving mental illness.

Keywords

Cultural Adaptation, Mental Illness, Health Seeking Behaviour, Caregivers

1. Introduction

Mental illness is a major concern globally. It is estimated that 792 million people across the world are suffering from mental illness. (Patel et al., 2018) states that improving care of people with mental illness has been overlooked in this case not much attention is paid despite its profound effect on an individual's wellbeing (Ritchie & Roser, 2018). According to Bourne, 2012 health seeking behaviour comprises among other elements, lack of support and cultural lineage. The approach to seeking help, especially for caregivers of people with mental illness is bi-dimensional evident (WHO, 2019) prioritizing a trained allopathic doctor in the formal or informal health care setting through referrals. Various contextual factors as often associated with preferences of traditional approaches to health seeking.

Societal and cultural contexts were critical for negotiating or constructing individual-level phenomena such as attitudes, behavior and knowledge. Health seeking behavior for people with mental illness is not evident due to cultural influences. The perceptions and attitudes towards the mentally ill, also interfere with techniques of diagnosis, prevention and treatment of the sickness (Subudhi, 2014). Therefore determination of cultural adaptive intervention in health seeking behaviour by caregivers of people with mental illness.

Cultural adaptation is whereby a community may decide to structure a practice to fit its preferred need. In relation to mental health delivery services, it adjusts to be in line with cultural competence.

This is basically how service delivery is modified to a specific practice, structure or language in the community.

Culture influences health and illness from the manner in which people conceptualize the illness, seek medical care, perceive health care providers, and accept medical care. According to Hernandez et al. (2009), cultural diversity worldwide significantly impacts many aspects of mental health including what is perceived as a problem, how such a problem is understood, and the acceptable solutions to the problem. Hechanova & Waelde (2017) have delineated five components inherent in the diverse cultures that have different connotations for mental health stakeholders. They identify emotional expression as the first component (Haque, 2010), and delineated shame (Hechanova & Waelde, 2017).

Existing literature confirms that different cultures construct health and illness differently (Gopalkrishnan, 2018; Fernando, 2014; Nguyen & Bornheimer, 2014). These scholars contend that the diversity in culture comes with consequences in terms of the motivation to seek treatment, coping with symptoms, family and community support, pathways taken to health care, and who to seek care from. Some cultures attribute onsets of mental illness to black magic, spirits, breaking of taboos, or "evil eye". In such a context, rectification of the problem is left to elders, traditional healers and other significant persons in the community (Helman, 2007). Religion and spirituality are also associated with such perceptions of onset of illness and therefore play a big role in rectification of the prob-

lem (Hechanova & Waelde, 2017).

Mental, neurological, and substance use (MNS) disorders are a leading cause of burden of disease as measured using disability-adjusted life years (DALYs) in Kenya (Meyer & Ndetei, 2016) Understanding people's attitudes and beliefs towards issues surrounding mental illness is the first step to effective treatment and sustainable recovery.

There has been very insufficient information as regards to treatment and behaviour of people with mental illness. It is consequently vital to study socio-cultural aspects of mental illness so that social and culturally pertinent actions can be taken, or strategies put in place in service provision such as socio-cultural guides in treatment strategies and other supportive mechanisms (Gopalkrishnan, 2018). This study sets grounds for research in this area since very few studies on community mental health have been conducted.

The study focuses on how caregivers of mentally ill patients seek help, in this case they adopt ways and means that are in tandem with the communities' expectation. Questions are asked rather than taking a prescriptive approach of what is expected to be done. A practice can be modified to fit a particular culture or community in this case it can be said that the culture has been accommodated in this particular community. There are a number of cultural adaptation practices whose approaches are promising though had not benefited from scientific research though through it is beneficial to practitioners and families because of the positive outcomes. Whether individuals seek specific services or not depends on how culture affects behavioural health. Minorities or those who are racially discriminated are more likely to turn to their primary health care provider for example clergy, traditional healers, family and friends than the privilege who may seek treatment from mental health specialists, cultural practices and beliefs and this leads to disparities of behavioural health.

1.1. Rational of the Study

This study was justified by evidence which shows that in spite of mental illness being one of the most disabling and chronic illness, health-seeking behaviour of caregivers of this illness in Kenya is alarmingly low (Persens, 2020). Kenya has taken the issue of mental illness seriously as manifested in the various development frameworks such as the Kenya Mental Health Policy (2015-2030), the constitution of Kenya 2010 and vision 2030. However, evidence shows that culture plays a significant role in the perception towards mental illness (Angermeyer & Dietrich, 2006; Ran et al., 2018). Yet still, contextual factors such as accessibility and continuity of healthcare have been associated with the urge to seek or not to seek help among mentally ill patients (Dassah et al., 2018; Fontanella et al., 2014; Musinguzi et al., 2018). This study focusing on caregiver cultural adaptation practices in health seeking behaviour was therefore deemed as a good step towards understanding and reducing the otherwise escalating cases of mental illness.

1.2. Theoretical Foundation of the Study

The works of Jean Piaget 1896-1980 attests that through experiences and interaction by sharing ideas humans make meanings which later become theories. This theories stresses on social constructed actions (Lev Vygotsky, 1978). In this case New Knowledge is constructed on the foundation of the existing ones determined by people's experiences in the community (Elliot et al., 2000). In this case already known information influences any new experiences learnt. Caregivers construct the understanding of mental illness and the mentally ill when they encounter one in their family or in their neighbourhood. This implies that constructivism is a people point of view in understanding a phenomenon that affects them.

The foundation of constructivism theory is rooted in both psychology and philosophy with its essential core being that there is active engagement of learners in construction of their own knowledge as well as interpretation of its meaning from their experiences (Applefield et al., 2000). This study is embedded sociocultural constructivism which is a sociological theory in which human development is socially situated and knowledge constructed through interactions with others. The theory can be redefined since it involves active cognitive processing.

The theory argues that what the individual believes is true, it is true indeed. (Bakker, 2007) contended that "if men define situations as real, they are real in their consequences". If you believe that mental illness is contagious then you act accordingly to avoid the mentally sick or those associated with them.

Individuals are encouraged to view themselves as active participants in their lives. Constructivism is a dynamic process of definition and redefinition of the situation in order to accommodate any changing circumstances. Therefore people in the community play a major role in "making meaning" constructs as to how individuals think and what they think about. (Glassman, 2001) study covers the theoretical philosophy, Cognition and social issues and culture embedded in individuals within different communities the study focusing on the communities in Uasin Gishu, thus the reason why constructivism theory was the foundation brought on board to construct the variable of Mental illness.

According to (Ratnapalan, 2008), culture is a complex whole bringing together knowledge, beliefs, morals, customs, law, and other capabilities which individuals acquire as members of a society (Loewenthal, 2006). (Pessoa & Deloumeaux, 2009) further adds that culture encompasses ways of coexisting, lifestyle, traditions, value systems, and beliefs. In essence then, culture and mental illness cannot be isolated as the mentally ill are certainly members of a cultural group. Subudhi (2014) contends that mental illness is a social construct which varies across cultures. Different cultures have divergent beliefs on the etiology, treatment and intervention of mental illness (Jimenez et al., 2012). This cultural adaptation perhaps accounts for the various perceptions of health seeking behavior for mental illness.

Similarly, evidence from Uganda confirms that culturally oriented interventions plays a major role in the preference of traditional health care approaches for

mental health. The sum total is that traditional healers are overwhelmed by the large burden of giving care to people with mental illness (Abbo, 2011). From the Nigerian context, it has been argued that the African society is quite complex, and has diverse religious and cultural practices (Chukwuneke et al., 2012). Such complexity and diversity in culture often reflects on individuals understanding and attitude of their health matters. According to Chukwuneke and the other scholars, the different cultures perceive causes of mental illness differently, and are bound to react differently towards health seeking behavior. They contend that most African communities have a preference for traditional healers due to the belief that traditional healers have powers to trace the source of patients' ailments by probing misfortunes in the natural, social and spiritual environments.

Kenya like other African countries has a diverse culture which is manifested through various ethnicities. Evidence shows that Kenya is ethnically diverse and has at least 42 tribes (Balaton-Chrimes, 2021). These ethnic groups differ in their comprehensions of the meaning of mental illness, causes and its management. The Bukusu sub-tribe of Bungoma District for instance define mental illness as the "wildest insanity" (Maithya, 1992). Maithya points out that as a result of comprehending mental illness in this manner; mental illness is received with a negative attitude within the sub-tribe. Such an attitude determines choice of preferred therapy for which, traditional healing is recognized as the source of effective health care. Although Maithya's findings could have been overtaken by time, recent studies continue to confirm that the negative attitude towards mental illness among the Bukusu still persists (Nandikove & Ng'ambwa, 2020).

In this case the study relates well with constructivism theory because caregivers of mentally ill patients derive the way they take care of patients from the information constructed by the people in the community within the society. Since little is known about how to take care of mentally ill patient, constructivism is criticized to attempt to make something out of nothing. It says little about the nature of the training people in the community get and then use to assist in health seeking behaviour.

The theory emphasizes that new information is incorporated into people's pre-existing knowledge (schemas). The theme in constructivism theory talks about how people learn through culture assimilation and constructivism.

Caregivers of mental illness develop an understanding within the community that permits them to act in a positive way as they take care of the mentally ill people.

2. Methods

The study was conducted at the Mental Health Unit of Moi Teaching and Referral Hospital (MTRH) in Eldoret town Uasin Gishu County, Kenya. MTRH is the biggest referral hospital in the western region of Kenya. It is located in an urban setting of Eldoret town, northwest of the former Rift Valley Province. It is used for the training of medical doctors, nurses, environmental health specialists, public health managers, pediatricians, internists, surgeons and family medicine specialists.

The study targeted caregivers of people with mental illness drawn from Uasin Gishu County attending mental health services at the MTRH and health care service providers drawn from the Mental Health Unit of the hospital. This, therefore, comprised the target population of study. In this case, the unit of analysis was the individual caregiver of mentally ill patients who accompanied patients to the unit, as well as the particular health care provider. Nevertheless, it is important to note that the actual number of people with mental illness in the County was not documented. The targeted population of caregivers of these people was therefore deemed as infinite.

Permission to conduct this study was sought for, and granted having been approved by the Institutional Research and Ethics Committee (IREC-MTRH-Moi University) and National Commission for Science Technology and Innovation (NACOSTI). Ethical principles were exercised.

This study used mainly primary data collected firsthand from caregivers of people with mental illness and healthcare service providers. It is postulated that, primary data relates to data which is collected firsthand from original sources. The basic aim was to select instruments which would ensure collection of valid and reliable data. In line with the three sets of participants identified for this study, three research instruments were employed to collect the required primary data. They included a structured questionnaire for caregivers of the mentally ill; a discussion guide for focus group discussion with caregivers; and an interview schedule for healthcare providers chosen as key informants. Use of these three tools was seen as a necessary aspect of triangulation of data collection tools aimed at enhancing validity by compensating for weaknesses of reliance on single data collection methods (Perlesz & Lindsay, 2003). Self-developed questionnaire guide was the main data collection instrument that focused on cultural adaptation practices for mental illness.

Focus group discussion guide was the second instrument used to collect data in this study. The discussions involved caregivers of people with mental illness who had no opportunity to participate through the questionnaire approach and whether there were case examples that could be used to justify construction of mental illness as a cultural perspective. The questions were open ended to allow for wider latitude of response from participating caregivers.

Key informant interview schedule focused on the healthcare service providers targeted, and a neighbour to one family with a mental illness patient. The key informants' interview schedule had four questions that participants were required to respond to. The first question sought views of key informants with regards to common perceptions about mental illness among communities under study. The second question sought to get views of key informants who were experts, on how mentally ill patients ought to be treated within families, in the community and in the hospital. Finally, key informants were asked to shed some light on challenges which caregivers of people with mental illness have encountered.

The researcher took the responsibility of moderating focus group discussions with selected caregivers and conducting interviews with key informants. In the case of focus group discussions, the researcher first identified two groups of eight caregivers each, agreed with them on discussion modalities and dates, and identified an assistant to take discussion notes.

Data were first screened and cleaned for missing data and outliers. This was subsequently followed with a descriptive analysis that explored the background characteristics surrounding the patient and illness; and prevailing status of indicators of cultural construction of mental illness within the study context. Next, thematic analyses were conducted using the FGD and interview data with the aim of identifying emerging themes regarding cultural construction of mental illness and mental health seeking behaviour. The final phase of data analysis examined the direct effects of cultural construction of mental illness indicators on health seeking behaviour among caregivers of people with mental illness and moderation effects of contextual factors on the relationship between cultural construction of mental illness indicators and health seeking behaviour. Hayes Macro "PROCESS" Model 1 which, is incorporated in the statistical packages for Social Sciences (Hayes & Rockwood, 2020) was employed to ascertain direct and moderation effects.

3. Results

Cultural Adaptation Interventions in Health-Seeking Behaviour

Caregivers of people with mental illness in Uasin Gishu County, reflected that cultural construction of mental illness, helps in their health seeking behaviours intervention strategies put in place for mentally ill patients.

Seven items reflecting various adaptive practices were employed. Caregivers were asked to indicate through agreement or disagreement the adaptation interventions undertaken for patients under their care. Results presented in **Table 1** confirm that several interventions are normally sought by mental illness caregivers. On the basis of proportions of agreements and mean response scores, mental illness is associated with demons leading to exorcism as the main cultural intervention adopted by communities under study. Other notable interventions included: consulting faith healers; community support programs; conducting family prayers; support from visitors; and resorting to herbal medicine.

Moderating effects of cultural intervention was postulated by Andrew Hayes Macro Process.

Under this approach, Hayes model 1 being entered as dependent variable was found to be most suitable with health seeking behavior, cultural construction of mental illness was entered as the independent variable and contextual factors as the moderating variable.

Most caregivers of people with mental illness seek cultural intervention for the mentally ill. Research shows that the need for cultural interventions to mental illness has been on the increase in recent years; with significant improvements in terms of recovery, self-efficacy, hope, and life quality being experienced by people

seeking cultural adaptive interventions (Daass-Iraqi et al., 2021).

Descriptive findings show various forms of cultural interventions among caregivers of people with mental illness in Uasin Gishu County.

From the results of the Hayes moderation test, the test of highest order unconditional interaction was significant, R^2-change = 0.0085, F (1, 445) = 6.3763, $p < 0.05$. This implies that contextual factors did moderate the relationship between cultural construction of mental illness and health seeking behavior. Besides, the conditional effect of cultural construction of mental illness at varying levels of contextual factors revealed as presented in Table 2.

At low levels of contextual factors, cultural construction of mental illness had a high negative and significant effect on health seeking behavior; b = −0.789, $p < 0.005$; at average levels of contextual factors, the effect was still negative and significant but moderate; b = −0.598, $p < 0.05$; and at high levels of contextual factors, the effect was negative, significant and lower, b = −0.407, $p < 0.05$.

The implication of these results is that contextual factors moderate the relationship between cultural construction of mental illness and health seeking behaviour. The declining absolute values of the coefficients indicate that high levels of contextual factors tend to reduce health seeking behavior among caregivers of mentally ill patients Braumoeller (2004).

Table 1. Care givers cultural adaptation practices.

Cultural adaptation indicators	SD	D	MA	A	SA	$\bar{X}$	S
1. I have been taking my patient for counseling sessions	0.4%	6.4%	22.9%	40.9%	29.3%	3.92	0.903
2. Community support programs have been very helpful	0.0%	0.4%	17.3%	49.1%	33.1%	4.15	0.708
3.We have been receiving support from people who visit our home	0.4%	2.9%	16.7%	46.2%	33.8%	4.10	0.807
4. I have often resorted to herbal medicine for my patient	0.0%	5.6%	20.7%	36.2%	37.6%	4.06	0.896
5. People have recommended exorcism arguing that my patient is a victim of demons	0.0%	1.8%	15.6%	40.7%	42.0%	4.23	0.772
6. We have often conducted prayers as a family	0.0%	4.7%	14.7%	42.7%	38.0%	4.14	0.834
7. In certain cases we have consulted faith healers	0.0%	1.1%	20.2%	36.9%	41.8%	4.19	0.793

Table 2. Tests of Highest order unconditional interaction and slopes.

Test of Highest order unconditional interaction						
	R^2-Chng	**F**	**df1**	**df2**	**P**	
X*W	0.0085	6.3763	1.0000	445.0000	0.0119	
Slopes for cultural construction of mental illness predicting health seeking behaviour at each level of contextual factors						
Contextual factors	**Effect (Cultural construction of mental illness)**	**SE**	**t**	**p**	**LLCI**	**ULCI**
Low	−0.7891	0.0928	−8.5020	0.0000	−0.9716	−0.6067
Average	−0.5982	0.0765	−7.8170	0.0000	−0.7486	−0.4478
High	−0.4072	0.1206	−3.3775	0.0000	−0.6441	−0.1703

The descriptive findings showing various forms of cultural interventions among caregivers of people with mental illness in Uasin Gishu County were reflected in results of thematic analyses of focused group discussions with selected caregivers. Through the third item on the FGD guide, the researcher sought to establish methods which were previously used to handle mental illness, and their effectiveness. Participants were asked to state the methods previously used. Prior to stating methods used, a participant from the second focused group had this to say:

> …that most common mental disorders in the community revolved around depression, schizophrenia, psychosis and alcohol abuse…for this reason traditional and faith healers were mostly sought after (FGD2).

Another participant belonging to the second discussion group observed the following:

> …previous methods of handling mental illness in this community centered on informal health care. Witchdoctors and herbalists were the main traditional healers and performed rituals or counseled patients (FGD 2).

A participant in the first group identified prayers as a method often used. She remarked that:

> ...we often had faith healers who used the power of prayers and counseling to treat mental illness patients (FGD 1).

The final item on the FGD guide sought to find out from the participating caregivers whether there were any cases in their communities that would justify culturally constructed perceptions of mental illness. From the discussions, one case scenario was narrated. This was the case of Mr. Kabii (not his real name). The following is a synopsis of Mr. Kabii's case:

> …As a young boy, Kabii who hails from Kabiyet division Kabisaga location, was naughty and was always fond of sexually molesting mentally impaired girls. Efforts to report him to authorities proved to be futile. One day, Kabii molested a mentally challenged girl, and despite being reported nothing was done. The mother of the victim proffered a curse on Kabii stating that he will never see peace in life.
>
> Incidentally, Kabii married a lady whose background had prior cases of mental illness. The couple ended up siring a number of mentally ill children. Subsequently, it emerged that Mrs. Kabii was also eliciting mental illness as were the 1st, 3rd, 4th and 6th children.
>
> The bottom line is that the community believed that the curse proffered on Kabii had taken effect, showing that mental illness could be culturally constructed. It is argued among the community that refusal by Mr. Kabii to appease the gods by slaughtering a bull, did result in the problems which have persisted in his family that have seen most of his family members become mentally ill.

On visiting the Kabiyet area, the researcher was able to see the deplorable condition that Mr. Kabii was living in. This photo for instance shows the interior of Mr. Kabii's house. As seen from the picture, nothing much can be made of the house. Some parts of the roof are missing.

The two photos of Kabii's house corroborate the findings which implied that most people with mental illness are housed in dingy houses that are mainly in poor state owing to the stigma associated with them.

The findings of cultural adaptation interventions from descriptive and thematic analyses imply that most communities resort to adaptive interventions grounded in diverse cultures and often revolving around traditional and faith healing. The findings which show exorcism, faith healing and herbal medicine as cultural interventions for the mentally ill are in concurrence with the findings by (Ndetei, 2013) which indicated that traditional and faith healers were preferred for their culturally acceptable treatment such as prayers and special rituals. The

thinking in some communities is that illnesses associated with mental disorder are best managed by traditional and faith healers (Musyimi et al., 2017). So long as they are committed in improving the lives of people in a joint dialogue collaborating with medical practitioners.

Resorting to exorcism as intervention as reported in the study is perhaps embedded in the beliefs across many cultures and religions (Sanford, 2016). According to Sanford, there is a belief in most of the cultures and religions that humans have the possibility to be inhabited or possessed by spirits. In this way exorcism was seen as a form of intervention aimed at expelling spirits from the subject's body and mind or both (Trethowan, 1976).

More or less same views were held by key informants such as administrators, psychiatrists, registrars and nurses drawn from the mental unit interviewed. Four items on the key informants' interview schedule were used to guide the interviews. Key informants were first asked to share their views with regard to perceptions of mental illness among the communities they serve. The main themes cutting across participants were that mental illness was as a result of curses, witchcraft or heredity. The first key informant (KI1) noted the following:

> …mental illness relates to the state where the brain does not function coherently, or the mind is disturbed. Most of these communities point towards curses, witchcraft and bad omens as the main causes of mental disorder (KI1).

A key informant, who is a neighbour to a family with a mental illness patient, remarked that:

> …I don't know what is happening. It is as if this family is cursed…they did not even have boys, it is only girls and yet they have issues with mental disorder (KI2).

Meanwhile, a third key informant reported that:

> …most of these communities believe that mental illness is caused by curses, or lack of appeasing gods for ill deeds committed previously. They reckon that failure to seek forgiveness is a recipe for mental illness (KI3).

Another key informant focused on what the community perceives as causes and symptoms of mental illness. This informant remarked that:

> …various factors that cause mental illness in these communities have been advanced, and include drug and alcohol abuse, stress, accidents and inheritance. To most members of the communities, mental illness manifests in the form of behavior changes, talking to oneself, and bizarre behavior (KI4).

While observing that inheritance plays a key role in mental illness, this fourth key informant narrated the case scenario of a young lady who was admitted to the MTRH mental unit because of abusing drugs, which in turn tended to trigger the latent history of mental illness in the family. He narrated the following regarding the lady:

> …this lady who hails from a single parent family scored KCPE results that did not please the mother who went on to berate her. On entering secondary school, the girl was then introduced to Cannabis Sativa (Bhang) by her form three boyfriend. The drive for this lady towards bhang was informed by the desire to get back to her mother, and as an avenue to perform better in secondary school as opposed to what she had in primary school.
>
> Indeed, she performed exemplary well in secondary school and joined a recognized public university. While in the university, the atmosphere of non-restriction made her venture more into other ways of maximizing her drug intake. This triggered a genetic mental illness problem that apparently runs in the family. Further investigations revealed that the lady's mother and uncle were persons with mental illness. In this case therefore, use of cannabis sativa only triggered this latent condition. Besides abusing drugs, the lady also had a bipolar disorder which had hitherto been unknown till she started abusing drugs. Continued abuse of drugs while in university made her to start missing classes and culminated in her being discontinued in order to allow her to work on her behavior and drug habits (KI4).

To the community, the lady was perceived to be alright until she became wild and started behaving weirdly. The community members believed that being a lone child, the lady had been cursed or bewitched and required divine intervention. Culturally a child born alone is a social misfit (2022). In an African setting, it is expected that a family should comprise two or more children if not it may be deemed as a curse though biomedically it may be secondary infertility that may be as a result of socio-cultural-environmental and genetic connotation. Nevertheless, this case scenario confirms that besides being a construction of culture, mental illness is a genetic condition that may run through families as presented in the case of a lady student who was admitted in MTRH mental ward.

The second item on the Key Informants Interview Schedule sought to understand from mental health experts how persons with mental illness ought to be treated within families; in the community; and in hospitals. On the question of how they should be treated at family levels, the main theme among the key informants was that of support. One informant indicated that:

> …depending on the environment and cultural lineage of the family, persons with mental illness require support at the family level. Consequently, they ought to be assisted to do what they are not able to do on their own, and do require close monitoring. Besides, they require understanding and to be provided with basic needs (KI5).

Meanwhile, another key informant noted that:

> …parents and siblings should be ready to support these people in terms of seeking medical care in order to try and suppress the problem (KI1).

Another key informant opined that:

> …these people should be supported to try and live normally. For instance, depending on the severity of the condition, those in marriage should be helped to overcome the condition and go on with their marriage life (KI4).

On the question of how people with mental illness should be treated in the community, the recurrent themes revolved around being understood and supported. One key informant stated that:

> …although mental illness is perceived differently from one community to the other, people with mental illness ought to be understood in their thinking and reasoning. They should be protected from harm by those who view them as a nuisance (KI3).

Another informant chipped in by stating that:

> …these individuals require community support and respect. Some of these people are undergoing a lot of stress in life, and failure to understand them only perpetuates the notion of witchcraft and being cursed. Efforts ought to be made to help those who abuse drugs to drop the practice and this is only possible through understanding them (KI2).

4. Discussion

Specific findings and subsequent discussions were based on the existing literature and conclusions drawn from the objective to explore the influence of cultural adaptation practices on mental health seeking behaviour by caregiver's mentally ill people in Uasin Gishu County.

The communities in the study area have heavily relied on cultural practices such as faith healing, herbal medication, traditional healing through witchcraft and exorcism and family prayers to intervene in mental illness which are mostly preferred in the county. The community has the perception that mental illness arises from curses as depicted by the case

The findings also show that most caregivers tended to prefer cultural adaptation practices which are consistent with the tenets of constructivism. In essence therefore, it may be argued that constructivism is responsible for diverse ways in which caregivers of people with mental illness embrace traditional forms of treatment, which are essentially cultural adaptation interventions. Through this finding therefore, it becomes apparent that caregivers of people with mental illness including family members, construct images of causes and treatment of mental illness based on family interactions.

However, the common forms of therapy included; prayers from home, consulting with traditional witchdoctors and herbalists, and formal treatment in the mental unit of the MTRH. This is consistent with the theory of health seeking behavior, which indicates that people are different in their willingness to seek health care services (Kanbarkar & Chandrika, 2017). In this difference, some people will readily go for treatment while others will only seek such services when in extreme pain. The findings bring forth important implications from a

cultural perspective which if harnessed, will facilitate efforts to address systemic challenges experienced in mental health in Kenya.

This is particularly so, given that culture has been shown to play an important role in perceptions elicited towards various illnesses in the society. (Shamsaei et al., 2015), for instance, contend that the diversity of cultures across the world comes with varying traditions and beliefs regarding various illnesses, and the manner in which they should be treated. This therefore confirms that culture remains integral to effective handling of health-related issues that emerge in the society.

The study demonstrated a high level of beliefs among the participating caregivers and practitioners showing that mental illness was a product of curses and non-appeasing of gods, which made caregivers to seek spiritual and religious healing methods. Removing this curse mentality would therefore be a precursor to any successful intervention.

The need for a mental health policy is further emboldened by findings showing that, most of the caregivers of people suffering from mental illness found the previous informal methods used for treating mental illness patients to be largely ineffective. Besides, the caregivers' views indicate that the negative attitude and lack of family and community support exacerbates spiritual and cultural perceptions towards mental illness. For instance, caregivers of people with mental illness are excluded from activities undertaken in communities as reported in this study, then it shows how deep beliefs of curses run among the respective communities. This implies that despite the Government taking on a noble mission of addressing mental illness through a policy framework, the role traditional and faith healers play in providing care to people suffering from mental illness need not be ignored. Anthropologists should seek to find ways through which they can engage community leaders to raise awareness on the need for care and quality life for people in the communities suffering from mental illness.

For social inclusivity of the mentally ill to be realized, communities need to therefore put in mechanisms through which people suffering from mental illness are supported to access care by the community as a whole instead of relegating support to the family and close relatives.

The finding showing that cultural adaptation practices positively and significantly impact health seeking behavior among caregivers of people with mental illness, augers well with the desire of the mooted Kenya Mental Health Policy to pursue a multi-sectoral approach, to maximize achievement of mental health goals (Mutiso, 2016). The finding confirms that besides use of formal approaches to treatment, mental illness which in the study context is mainly caused by drug and alcohol abuse, stress and heredity is often successfully treated using cultural interventions. The implication here is that a participatory approach to the delivery of interventions, which maximizes contributions of different actors, is the surest way of attaining the best possible outcomes in mental health interventions.

The desire for the participatory approach to delivery of interventions is informed by the array of studies which underscore the importance of community interventions in mental health. (Castillo et al., 2019) for instance concluded that, community interventions were effective at various social-ecological levels. Meanwhile, Webber & Fendt-Newlin (2017) indicated that social participatory interventions for people with mental problems had some degree of effectiveness in increasing individuals' social networks. (Ma et al., 2020) on the other hand demonstrated the effectiveness of participatory interventions in reducing objective and subjective social isolation. (Webber & Fendt-Newlin, 2017) provided evidence of use of social participation intervention to enhance inclusivity of adults with mental health problems in communal affairs.

Perhaps the striking finding made by this study, and which carries a lot of implications for the practice of mental health care, is the moderating potential of contextual factors such as comprehensiveness of care, accessibility, coverage and continuity in the relationship between cultural construction of mental illness and the desire to seek help. As a matter of fact, the situational analysis in line with the Kenya Mental Health Policy (2015-2030) identifies inequity in the distribution of skilled human resource for mental health as a major global concern (Marangu et al., 2021). According to the World Health Organization (WHO) in its report titled "The Global Burden of Disease" (Lopez, 2006), four out of five people living with serious mental disorders in low and middle income countries are estimated to go without receiving mental health services because of lack of access.

This study revealed scarcity in mental health facilities and medication across the county, and lack of access to services for people with mental illness. This could have in a way contributed to the moderating influence of contextual factors on the relationship between cultural construction of mental illness and health seeking behavior. Accessibility to health care is an integral element of factors in the context that play part in heath matters. It should be borne in mind that Uasin Gishu County is largely made up of rural areas making accessibility to mental facilities to be a challenge. It has been demonstrated that rurality has a negative impact on mental health owing to the issue of accessibility (Murray et al., 2004). Meanwhile, Uasin Gishu as a county is also made up of urban centers and towns, which raises chances of serious mental illness. Drug and alcohol abuse are normally rampant in urban dwellings. Moreover, it has been shown that chances of serious mental illness such as schizophrenia are higher in cities than in rural areas (Gruebner et al., 2017). In such a situation, lack of access to mental health services as was the case in this study becomes a major contextual concern, and could have been the reason for the apathy towards health seeking behavior experienced among caregivers of people with mental in the study area.

5. Conclusion

The finding showing the use of a variety of cultural adaptation interventions to

address mental health in the communities under study, calls for synergy between formal and informal health care services. The combined influence of social systems in a community, and collective resources, has the potential to address community problems while at the same time broadening opportunities (George et al., 2016). The synergy between traditional mental health practitioners, and formal mental health workers, may influence mental health seeking, and promotion strategies through which efficacious professional health strategies can be identified and applied.

The findings of this study have important ramifications for mental illness and health seeking behaviour for caregivers. However, by delimiting the geographical scope of this study to one county, it may not be prudent to generalize the findings to the other remaining 46 counties.

6. Recommendations

The finding showing use of a variety of cultural adaptation interventions to address mental health in the communities under study, calls for synergy between formal and informal health care services. The study recommends investing in health systems with a view to understanding factors that inform treatment processes in the context of mental illness. It has been shown that the combined influence of social systems in a community, and collective resources, has the potential to address community problems while at the same time broadening opportunities (George et al., 2016). The researcher believes that through synergy between traditional mental health practitioners, and formal mental health workers, additional factors that may influence mental health help-seeking, and effective strategies that can promote professional help-seeking can be identified.

Relying on purposive sampling without having a clear criterion for making judgment introduces a subjective and non-representative approach that limits external validity. There is a need for scholars wishing to replicate this study to consider random sampling techniques when identifying caregivers of people with mental illness. This will not only improve the overall representativeness but will also allow for generalization of findings to a wider scope of communities.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

Abbo, C. (2011). Profiles and Outcome of Traditional Healing Practices for Severe Mental Illnesses in Two Districts of Eastern Uganda. *Global Health Action, 4,* Article No. 7117. https://doi.org/10.3402/gha.v4i0.7117

Angermeyer, M. C., & Dietrich, S. (2006). Public Beliefs about and Attitudes towards People with Mental Illness: A Review of Population Studies. *Acta Psychiatrica Scandinavica, 113,* 163-179. https://doi.org/10.1111/j.1600-0447.2005.00699.x

Applefield, J. M., Huber, R., & Moallem, M. (2000). Constructivism in Theory and Prac-

tice: Toward a Better Understanding. *The High School Journal, 84,* 35-53.

Bakker, J. I. (Hans) (2007). Definition of the Situation. In G. Ritzer (Ed.), *The Blackwell Encyclopedia of Sociology* (pp. 1-2). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781405165518.wbeosd012

Balaton-Chrimes, S. (2021). Who are Kenya's 42(+) Tribes? The Census and the Political Utility of Magical Uncertainty. *Journal of Eastern African Studies, 15,* 43-62. https://doi.org/10.1080/17531055.2020.1863642

Braumoeller, B. F. (2004). Hypothesis Testing and Multiplicative Interaction Terms. *International Organization, 58,* 807-820. https://doi.org/10.1017/S0020818304040251

Castillo, E. G., Ijadi-Maghsoodi, R., Shadravan, S., Moore, E., Mensah, M. O., Docherty, M. et al. (2019). Community Interventions to Promote Mental Health and Social Equity. *Current Psychiatry Reports, 21,* Article No. 35. https://doi.org/10.1007/s11920-019-1017-0

Chukwuneke, F. N., Ezeonu, C. T., Onyire, B. N., & Ezeonu, P. O. (2012). Culture and Biomedical Care in Africa: The Influence of Culture on Biomedical Care in a Traditional African Society, Nigeria, West Africa. *Nigerian Journal of Medicine, 21,* 331-333.

Daass-Iraqi, S., Epstein, P., & Roe, D. (2021). Cultural Adaptation of the Illness Management and Recovery Intervention among Israeli Arabs. *Psychiatric Services, 72,* 848-852. https://doi.org/10.1176/appi.ps.202000175

Dassah, E., Aldersey, H., McColl, M. A., & Davison, C. (2018). Factors Affecting Access to Primary Health Care Services for Persons with Disabilities in Rural Areas: A "Bestfit" Framework Synthesis. *Global Health Research and Policy, 3,* Article No. 36. https://doi.org/10.1186/s41256-018-0091-x

Elliot, S., Kratochwill, T., Littlefield-Cook, J., & Travers, J. (2000). *Educational Psychology: Effective teaching, effective learning* (3rd ed.). McGraw Hill.

Fernando, S. (2014). *Race and Culture in Psychiatry (Psychology Revivals).* Routledge. https://doi.org/10.4324/9781315733340

Fontanella, C. A., Guada, J., Phillips, G., Ranbom, L., & Fortney, J. C. (2014). Individual and Contextual-Level Factors Associated with Continuity of Care for Adults with Schizophrenia. *Administration and Policy in Mental Health and Mental Health Services Research, 41,* 572-587. https://doi.org/10.1007/s10488-013-0500-x

George, A. S., Scott, K., Mehra, V., & Sriram, V. (2016). Synergies, Strengths and Challenges: Findings on Community Capability from a Systematic Health Systems Research Literature Review. *BMC Health Services Research, 16,* Article No. 623. https://doi.org/10.1186/s12913-016-1860-1

Glassman, M. (2001). Dewey and Vygotsky: Society, Experience, and Inquiry in Educational Practice. *Educational Researcher, 30,* 3-14. https://doi.org/10.3102/0013189X030004003

Gopalkrishnan, N. (2018). Cultural Diversity and Mental Health: Considerations for Policy and Practice. *Frontiers in Public Health, 6,* Article No. 179. https://doi.org/10.3389/fpubh.2018.00179

Gruebner, O., A. Rapp, M., Adli, M., Kluge, U., Galea, S., & Heinz, A. (2017). Cities and Mental Health. *Deutsches Ärzteblatt International, 114,* 121-127. https://doi.org/10.3238/arztebl.2017.0121

Haque, A. (2010). Mental Health Concepts in Southeast Asia: Diagnostic Considerations and Treatment Implications. *Psychology, Health & Medicine, 15,* 127-134. https://doi.org/10.1080/13548501003615266

Hayes, A. F., & Rockwood, N. J. (2020). Conditional Process Analysis: Concepts, Computation, and Advances in the Modeling of the Contingencies of Mechanisms. *American*

Behavioral Scientist, 64, 19-54. https://doi.org/10.1177/0002764219859633

Hechanova, R., & Waelde, L. (2017). The Influence of Culture on Disaster Mental Health and Psychosocial Support Interventions in Southeast Asia. *Mental Health, Religion & Culture, 20,* 31-44. https://doi.org/10.1080/13674676.2017.1322048

Helman, C. (2007). *Culture, Health and Illness*. CRC Press. https://doi.org/10.1201/b13281

Hernandez, M., Nesman, T., Mowery, D., Acevedo-Polakovich, I. D., & Callejas, L. M. (2009). Cultural Competence: A Literature Review and Conceptual Model for Mental Health Services. *Psychiatric Services, 60,* 1046-1050. https://doi.org/10.1176/ps.2009.60.8.1046

Jimenez, D. E., Bartels, S. J., Cardenas, V., Dhaliwal, S. S., & Alegría, M. (2012). Cultural Beliefs and Mental Health Treatment Preferences of Ethnically Diverse Older Adult Consumers in Primary Care. *The American Journal of Geriatric Psychiatry, 20,* 533-542. https://doi.org/10.1097/JGP.0b013e318227f876

Kanbarkar, P. N., & Chandrika, K. (2017). Health Care Seeking Behaviour—A Theoretical Perspective. *Paripex Indian Journal of Research, 6*. https://www.semanticscholar.org/paper/Health-care-seeking-behaviour-A-theoretical-kanbarkar-Chandrika/1db246ffa86566bd9d108bd73babff5b089b1569

Loewenthal, K. (2006). *Religion, Culture and Mental Health*. Cambridge University Press.

Lopez, A. D., Mathers, C. D., Ezzati, M., Jamison, D. T., & Murray, C. J. (2006). Measuring the Global Burden of Disease and Risk Factors, 1990-2001. In A. D. Lopez, C. D. Mathers, M. Ezzati, D. T Jamison, & C. J. L. Murray (Eds.), *Global Burden of Disease and Risk Factors* (pp. 1-14). World Bank. https://doi.org/10.1596/978-0-8213-6262-4

Ma, R., Mann, F., Wang, J., Lloyd-Evans, B., Terhune, J., Al-Shihabi, A., & Johnson, S. (2020). The Effectiveness of Interventions for Reducing Subjective and Objective Social Isolation among People with Mental Health Problems: A Systematic Review. *Social Psychiatry and Psychiatric Epidemiology, 55,* 839-876. https://doi.org/10.1007/s00127-019-01800-z

Maithya, H. M. (1992). *The Awareness and Management of Mental Illness among the Babukusu of Bungoma District*. University of Nairobi.

Marangu, E., Mansouri, F., Sands, N., Ndetei, D., Muriithi, P., Wynter, K., & Rawson, H. (2021). Assessing Mental Health Literacy of Primary Health Care Workers in Kenya: A Cross-Sectional Survey. *International Journal of Mental Health Systems, 15,* Article No. 55. https://doi.org/10.1186/s13033-021-00481-z

Meyer, A.-C., & Ndetei, D. (2016). *Providing Sustainable Mental Health Care in Kenya: A Demonstration Project*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK350312/

Murray, G., Judd, F., Jackson, H., Fraser, C., Komiti, A., Hodgins, G. et al. (2004). Rurality and Mental Health: The Role of Accessibility. *Australian & New Zealand Journal of Psychiatry, 38*, 629-634. https://doi.org/10.1080/j.1440-1614.2004.01426.x

Musinguzi, G., Anthierens, S., Nuwaha, F., Van Geertruyden, J. P., Wanyenze, R. K., & Bastiaens, H. (2018). Factors Influencing Compliance and Health Seeking Behaviour for Hypertension in Mukono and Buikwe in Uganda: A Qualitative Study. *International Journal of Hypertension, 2018,* Article ID: 8307591. https://doi.org/10.1155/2018/8307591

Musyimi, C. W., Mutiso, V. N., Ndetei, D. M., Unanue, I., Desai, D., Patel, S. G. et al. (2017). Mental Health Treatment in Kenya: Task-Sharing Challenges and Opportunities among Informal Health Providers. *International Journal of Mental Health Systems, 11,* Article No. 45. https://doi.org/10.1186/s13033-017-0152-4

Mutiso, V. (2016). *Multi-Sectoral Stakeholder TEAM Approach to Scale-Up Community Mental Health in Kenya (TEAM).* https://www.mhinnovation.net/sites/default/files/downloads/innovation/reports/TEAM%20Project%20Report%20to%20County_Final_31_01_17.pdf

Nandikove, P., & Ng'ambwa, T. O. (2020). Community Perceptions on Mental Illness in Bungoma County, Kenya. *IOSR Journal of Dental and Medical Sciences, 19,* 45-52.

Ndetei, D. M., Mbwayo, A. W., Mutiso, V. N., Khasakhala, L. L., & Chege, P. M. (2013). *Traditional Healers and Their Provision of Mental Health Services in Cosmopolitan Informal Settlements in Nairobi, Kenya.* African Technology Policy Studies (ATPS).

Nguyen, D., & Bornheimer, L. A. (2014). Mental Health Service Use Types among Asian Americans with a Psychiatric Disorder: Considerations of Culture and Need. *The Journal of Behavioral Health Services & Research, 41,* 520-528. https://doi.org/10.1007/s11414-013-9383-6

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P. et al. (2018). The Lancet Commission on Global Mental Health and Sustainable Development. *The Lancet, 392,* 1553-1598. https://doi.org/10.1016/S0140-6736(18)31612-X

Perlesz, A., & Lindsay, J. (2003). Methodological Triangulation in Researching Families: Making Sense of Dissonant Data. *International Journal of Social Research Methodology, 6,* 25-40. https://doi.org/10.1080/13645570305056

Persens, L. N. (2020). *Right of Access after Taking over Care. Analysis of Recent Case Law from the European court of Humans rights.* Master's thesis, UiT Norwegian Arctic University.

Pessoa, J., & Deloumeaux, L. (2009). *The 2009 UNESCO Framework for Cultural Statistics (FCS).* United Nations Educational, Scientific and Cultural Organization.

Ran, M. S., Zhang, T. M., Wong, I. Y. L., Yang, X., Liu, C. C., Liu, B. et al. (2018). Internalized Stigma in People with Severe Mental Illness in Rural China. *International Journal of Social Psychiatry, 64,* 9-16. https://doi.org/10.1177/0020764017743999

Ratnapalan, L. (2008). E. B. Tylor and the Problem of Primitive Culture. *History and Anthropology, 19,* 131-142. https://doi.org/10.1080/02757200802320934

Ritchie, H., & Roser, M. (2018, April 25). *Mental Health. Our World in Data.* Our World in Data. http://ourworldindata.org/mental-health

Sanford, J. R. (2016). Facing Our Demons: Psychiatric Perspectives on Exorcism Rituals. *The Hilltop Review, 8,* Article No. 16.

Shamsaei, F., Cheraghi, F., & Esmaeilli, R. (2015). The Family Challenge of Caring for the Chronically Mentally Ill: A Phenomenological Study. *Iranian Journal of Psychiatry and Behavioral Sciences, 9,* Article No. e1898. https://doi.org/10.17795/ijpbs-1898

Subudhi, C. (2014). Culture and Mental Illness. In A. Francis, P. La Rosa, L. Sankaran, & S. P. Rajeev (Eds.), *Social Work Practice in Mental Health: Cross-Cultural Perspectives* (pp. 132-140). Allied Publishers.

Trethowan, W. H. (1976). Exorcism: A Psychiatric Viewpoint. *Journal of Medical Ethics, 2,* 127-137.

Vygotsky, L. S. (1978). *Mind in Society: The Development of Higher Psychological Processes.* Harvard University Press.

Webber, M., & Fendt-Newlin, M. (2017). A Review of Social Participation Interventions for People with Mental health Problems. *Social Psychiatry and Psychiatric Epidemiology, 52,* 369-380. https://doi.org/10.1007/s00127-017-1372-2

World Health Organization (WHO) (2019). *WHO Global Report on Traditional and Complementary Medicine 2019.* World Health Organization.