



Cultural Beliefs and Mental Health in Eha-Amufu Communities

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ABSTRACT

Background. Mental disorders impose a substantial and largely untreated burden in rural Nigeria, where supernatural explanations of illness, stigma, and reliance on spiritual and traditional healers shape how communities respond to psychological distress.

Objective. Guided by Kleinman's explanatory models, stigma theory and the theory of planned behaviour, this survey examined how cultural beliefs about mental illness relate to social distance, attitudes toward professional help-seeking, and psychological distress among adults in Eha-Amufu, Isi-Uzo Local Government Area, Enugu State.

Methods. A multistage cluster sample of 402 adults (response rate 95.0%) completed Igbo, English versions of a Supernatural Causal Beliefs Scale, a Traditional or Spiritual Healing Preference Scale, the Social Distance Scale, the ATSPPH-SF and the Kessler K10. All scales showed good internal consistency ($\alpha = .84-.90$; $\omega = .84-.90$).

Results. Controlling for age, gender, education and prior contact, supernatural causal beliefs predicted greater social distance ($\beta = .41$, $p < .001$, $\Delta R^2 = .155$, $f^2 = .20$). Supernatural beliefs ($\beta = -.23$) and traditional healing preference ($\beta = -.27$) jointly explained additional variance in help-seeking attitudes ($\Delta R^2 = .162$, $f^2 = .22$). Help-seeking attitudes partially mediated the association between supernatural beliefs and distress (indirect effect = 0.93, 95% bootstrap CI [0.55, 1.37]), accounting for 44.2% of the total effect.

Conclusions. Culturally grounded mental health literacy programmes that engage faith and traditional leaders are recommended.

Keywords: cultural beliefs, explanatory models, mental illness stigma, help-seeking attitudes, psychological distress, Eha-Amufu, Nigeria

1. Introduction

Mental disorders are among the leading causes of disability worldwide, and the gap between need and service provision is widest in low- and middle-income countries (Patel et al., 2018). The World Health Organization



(2022) reported that most people with mental health conditions receive no effective care, and that the treatment gap is most severe in sub-Saharan Africa. In Nigeria, the Nigerian Survey of Mental Health and Well-Being found that a meaningful proportion of adults experience a diagnosable disorder in their lifetime, yet only a small minority receive treatment (Gureje et al., 2006). The National Mental Health Act 2021 signalled renewed policy commitment, but translating legislation into accessible community services remains difficult (Federal Republic of Nigeria, 2021).

How communities understand the causes of mental illness strongly influences whether distress is recognised, whom people consult, and how those who are affected are treated (Kleinman, 1980). Across Nigeria, mental illness is often attributed to witchcraft, evil spirits, divine punishment or the violation of taboos, and such beliefs coexist with biomedical and psychosocial explanations (Gureje et al., 2005; Kabir et al., 2004; Labinjo et al., 2020). Among the Igbo of south-eastern Nigeria, cosmological concepts that link misfortune to ancestral relations, moral transgression and spiritual attack remain influential (Ikwuka et al., 2014). Patients and families frequently turn first to prayer houses, churches and traditional healers, and reach psychiatric services only after long delays (Aniebue & Ekwueme, 2009; Burns & Tomita, 2015).

Eha-Amufu is a predominantly agrarian Igbo community in Isi-Uzo Local Government Area. It combines strong Christian practice with enduring traditional institutions, is several hours by road from specialist neuropsychiatric services in Enugu metropolis, and has experienced recurrent insecurity associated with farmer and herder conflict. Residents therefore face elevated psychosocial stressors while having limited access to formal care. Community-based quantitative evidence from rural south-eastern Nigeria remains sparse. Most prior work has been descriptive and has not estimated effect sizes after education, age, gender and personal contact are accounted for.

1.1 Purpose and hypotheses

The study sought to describe supernatural causal beliefs and the distribution of distress; to test whether those beliefs predict social distance beyond sociodemographic factors; to test whether beliefs and preference for traditional or spiritual healing predict attitudes toward professional help; and to test whether help-seeking attitudes mediate the association between supernatural beliefs and distress.

Three hypotheses were tested at .05. H1: supernatural causal beliefs will positively predict desire for social distance after age, gender, education and prior contact are controlled. H2: supernatural beliefs and healing preference will jointly and independently predict less favourable professional help-seeking attitudes after the same covariates. H3: help-seeking attitudes will mediate the positive association between supernatural beliefs and psychological distress. The findings are expected to benefit the Enugu State Ministry of Health, religious and traditional leaders who are often the first point of contact, teacher-education institutions in the community, and researchers who lack a psychometrically documented dataset from this rural Igbo setting.

2. Theoretical framework and related evidence

Kleinman (1980) proposed that individuals hold explanatory models about the cause, course and appropriate treatment of illness, and that health care operates in popular, folk and professional sectors. In many African communities the folk sector is accessible and culturally congruent, whereas the professional sector is geographically distant (Gureje et al., 2015). People who attribute mental illness to witchcraft, possession or taboo violation are therefore expected to view spiritual remedies as the logical response.

Link and Phelan (2001) defined stigma as labelling, stereotyping, separation, status loss and discrimination. Desire for social distance is a common behavioural marker (Link et al., 1987). Supernatural explanations often carry moral and lineage connotations, which can intensify separation (Ikwuka et al., 2016). Ajzen's (1991) theory of planned behaviour treats attitudes as a proximal determinant of help-seeking. Unfavourable attitudes may delay treatment and allow distress to persist (Burns & Tomita, 2015).

Kabir et al. (2004) surveyed adults in Karfi village in northern Nigeria and found frequent attributions to drug misuse, divine will and spirit possession, together with negative views about work and marriage. In Yoruba-speaking south-western states, Gureje et al. (2005) reported that substance misuse was the most commonly cited cause, but that possession by evil spirits was also commonly endorsed, alongside strong reluctance to work with or marry someone with mental illness. Ikwuka et al. (2014) showed that Igbo respondents often hold biomedical and supernatural beliefs at the same time. Labinjo et al. (2020) reviewed 64 Nigerian studies and found that supernatural causes were the most commonly perceived determinants, that social distancing appeared in every attitude study, and that traditional and spiritual homes were first treatment options in 17 studies.

Adewuya and Makanjuola (2008) reported high social distance in south-western Nigeria, especially for intimate relationships such as marriage. Ikwuka et al. (2016) described the contradictions of a communitarian culture: although Igbo values emphasise collective responsibility, 61.6% of respondents would not marry someone who had recovered from mental illness. Aniebue and Ekwueme (2009), working in Enugu, found that prayer houses were the most common first option among psychiatric patients (34.5%), followed by the psychiatric hospital (32%). Burns and Tomita (2015) showed that traditional or religious healers commonly precede formal care across Africa. Gureje et al. (2015) recommended collaborative models rather than exclusion of the folk sector. Few studies have joined beliefs, help-seeking attitudes and measured distress in one community model from rural Enugu.

3. Methods

A cross-sectional correlational survey was conducted in four geographically contiguous clusters in Eha-Amufu. Cochran's formula for a proportion ($p = .50$, $e = .05$) yielded 384, raised to 423 for non-response. Power analysis for the R^2 increment in H_2 ($f^2 = .04$, power = .95) required 390. Households were sampled systematically and one

adult per household was selected with the Kish grid. Of 423 questionnaires, 402 were usable (95.0%). Mean age was 40.0 years (SD = 12.2); 51.2% were women; 81.6% identified as Christian; 30.1% had no formal or only primary education; 38.6% personally knew someone with mental illness.

English instruments were translated into Igbo and back-translated (Beaton et al., 2000). An expert panel comprising a psychiatrist, a clinical psychologist and a measurement specialist reviewed items for content validity. Interviewers read items aloud for participants with limited literacy. The eight-item Supernatural Causal Beliefs Scale was adapted from Ikwuka et al. (2014) and contextualised with Igbo concepts such as *nsi* (poisoning through spiritual means) and *nso ala* (taboo against the land). The six-item Healing Preference Scale assessed preference for consulting native doctors (*dibia*), prayer houses and spiritual churches rather than hospitals. Social distance used seven items from Link et al. (1987), scored 0–21. Help-seeking used the 10-item ATSPPH-SF, scored 0–30. Distress used the K10, scored 10–50, with Andrews and Slade (2001) bands of low (10–15), moderate (16–21), high (22–29) and very high (30–50).

In the main sample α and ω were .84–.90. Average variance extracted ranged from .45 to .50. Discriminant validity was supported because the square root of each construct's AVE exceeded its largest correlation with any other construct. Data were collected over six weeks by the researchers and six trained research assistants fluent in Igbo and English. Community leaders permitted the study. Consent was written or by thumbprint. Interviewers referred very high K10 scorers to primary care and the Federal Neuro-Psychiatric Hospital, Enugu. Hierarchical regression and a PROCESS-equivalent mediation model with 5,000 bootstrap draws were used. Harman's single-factor test did not indicate a dominant method factor.

4. Results

Table 1. Sociodemographic characteristics of participants ($N = 402$)

Characteristic	Category	n	%
Gender	Female	206	51.2
	Male	196	48.8
Education	None or primary	121	30.1
	Secondary	165	41.0
	Tertiary	116	28.9
Religion	Christianity	328	81.6
	African Traditional Religion	50	12.4
Occupation	Farming	144	35.8
Knew someone with mental illness	Yes	155	38.6

Note. Age $M = 40.0$ years, $SD = 12.2$, range 18–80.

More than four in five participants endorsed at least one supernatural cause, and the mean belief score lay above the scale midpoint ($M = 3.23$, $SD = 0.84$). The item stating that only spiritual intervention can fully cure serious mental illness was endorsed by 45.8%. Many respondents were undecided rather than firmly committed,

echoing Ikwuka et al.'s (2014) observation that Igbo respondents often combine supernatural and naturalistic explanations. On the K10, 42.0% scored in the high or very high range.

Table 1b. Endorsement of supernatural causal belief items

Belief item (agree %)	Agree	Undecided	M
Witchcraft or nsi from enemies	38.6	35.6	3.21
Evil spirits or possession	40.8	32.6	3.25
Punishment from God or the gods	42.5	29.1	3.21
Breaking nso ala (land taboo)	41.8	29.4	3.22
Ancestral or family curse	44.8	28.9	3.28
Only spiritual intervention can fully cure	45.8	26.4	3.28

Note. Agree combines agree and strongly agree. Scale 1–5.

Table 2. Reliability and convergent validity of study constructs (N = 402)

Construct	Items	α	ω	AVE
Supernatural causal beliefs	8	.87	.87	.45
Healing preference	6	.84	.84	.48
Social distance	7	.87	.88	.50
Help-seeking attitudes	10	.90	.90	.48
Psychological distress (K10)	10	.89	.89	.46

Note. AVE = average variance extracted. All standardised loadings exceeded .50.

Table 3. Hierarchical models for social distance (H1) and help-seeking attitudes (H2)

Outcome and predictor	β	ΔR^2	f^2	p
H1 Social distance				
Supernatural beliefs	.41	.155	.20	< .001
H2 Help-seeking attitudes				
Supernatural beliefs	-.23	.162	.22	< .001
Healing preference	-.27			< .001

Note. Covariates at Step 1: age, gender, education and prior contact. H2 ΔR^2 is the joint increment of beliefs and healing preference. H2 Step 1 R^2 = .108; full R^2 = .270.

Table 4. Mediation of supernatural beliefs on distress through help-seeking attitudes (H3)

Path	b	β	p or 95% CI
a Beliefs → attitudes	-2.92	-.34	p < .001
b Attitudes → distress	-0.32	-.28	p < .001
c Total beliefs → distress	2.10	.22	p < .001
c' Direct effect	1.17	.12	p = .021
Indirect a × b	0.93	.095	[0.55, 1.37]

Note. Completely standardised indirect effect = .095. Proportion of total effect mediated = 44.2%.

H1, H2 and H3 were supported. Education predicted more favourable help-seeking at Step 1, but much of the education effect on social distance was absorbed once beliefs were entered. Prior contact was not significant in the final models, possibly because contact in this setting often occurs with untreated and severely ill persons.

5. Discussion

Supernatural explanations were widely held, consistent with Nigerian reviews (Labinjo et al., 2020; Gureje et al., 2005; Kabir et al., 2004). The relatively high endorsement of exclusive spiritual cure links causal beliefs

directly to treatment expectations, as Kleinman's (1980) framework predicts. Ambivalence among many respondents is an opportunity for education. The K10 distribution signals a substantial burden of anxiety and depressive symptoms in a community facing agrarian pressure and insecurity, consistent with high unmet need (Gureje et al., 2006).

The medium effect of beliefs on social distance supports Link and Phelan's (2001) account of labelling and separation. In the Igbo context, beliefs that illness reflects a family curse, taboo violation or divine punishment attach moral blame to the lineage as well as the individual, which helps explain reluctance to form intimate ties such as marriage (Ikwuka et al., 2016). Healing preference predicted help-seeking attitudes at least as strongly as causal beliefs, which fits the theory of planned behaviour (Ajzen, 1991) and Enugu pathway-to-care findings (Aniebue & Ekwueme, 2009; Burns & Tomita, 2015).

Partial mediation (44.2%) suggests that culturally shaped reluctance to use professional services is one route from beliefs to ongoing distress, not the only route. The remaining direct effect may reflect fear, rumination about spiritual attack or anticipated stigma. Because the data are cross-sectional, people in greater distress may also be more inclined to adopt supernatural explanations.

The study contributes to theory in three ways. First, it provides quantitative support for Kleinman's (1980) explanatory models framework in a rural African community by showing that causal explanations are associated not only with treatment preferences but also with evaluative attitudes toward professional care and with reported distress. Second, it links explanatory models to stigma theory by demonstrating that supernatural attributions carry measurable consequences for social distance, which suggests that, in communitarian cultures, the moral and lineage-based content of causal beliefs may be a key ingredient of separation (Link & Phelan, 2001). Third, by integrating the theory of planned behaviour, the study positions help-seeking attitudes as a proximal and potentially modifiable link between culturally embedded beliefs and well-being. The finding that healing preference and supernatural beliefs contributed independently to attitudes indicates that these constructs should be measured separately in future models rather than combined into a single index of traditionalism.

Self-report and interviewer administration may have invited social desirability, particularly for beliefs that participants might expect researchers to disapprove of. Although Harman's test did not indicate a dominant method factor, that test is not a definitive safeguard. The two new scales need confirmatory factor analysis and test-retest work. The K10 does not establish clinical diagnoses. Findings are from one rural community, which limits generalisability to urban populations and other ethnic groups. Future research should compare rural and urban Enugu communities, incorporate qualitative methods to understand how people reconcile supernatural and biomedical explanations, and evaluate interventions co-delivered with religious leaders. Collaborative models with faith and traditional healers remain the practical next step (Gureje et al., 2015).

Programme planners in Enugu State now have locally grounded estimates of how strongly cultural beliefs relate to stigma, help-seeking dispositions and distress. Effect sizes were medium for both social distance ($f^2 = .20$) and help-seeking attitudes ($f^2 = .22$). These magnitudes are large enough to justify community mental health literacy and anti-stigma work, and they identify help-seeking attitudes as a plausible point of intervention. Implementation of the National Mental Health Act 2021 in Enugu State should include resources for culturally adapted community services in rural areas, not only specialist posts in the metropolis.

6. Conclusion and recommendations

Cultural beliefs in Eha-Amufu are closely associated with how people regard those who are affected, how they evaluate professional care, and how much distress they report. Adding clinics without addressing explanation and first-contact healers is unlikely to close the treatment gap.

The Enugu State Ministry of Health and Isi-Uzo primary care should implement Igbo-language literacy campaigns that present psychosocial explanations as compatible with faith. Religious bodies and traditional institutions should have structured referral protocols. Primary care workers should screen with brief tools such as the K10 and provide basic psychosocial support. Anti-stigma work should target family-level shame. Teacher-education institutions in the community should integrate mental health literacy into their curricula.

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