



Sociocultural considerations of mental health care and help-seeking in Uganda

Ronald Asimwe^{a,*}, Racheal D. Nuwagaba-K^b, Lekie Dwanyen^a, Rosco Kasujja^c

^a Department of Human Development and Family Studies, Michigan State University, East Lansing, MI, USA

^b Department of Counseling Indiana University of Pennsylvania USA

^c Department of Mental Health, Makerere University, Kampala, Uganda

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ABSTRACT

Sociocultural factors largely shape how communities conceptualize, express, and respond to mental and relational health problems. This paper reviews and summarizes literature on mental health in Uganda, with specific attention to Uganda's mental health policy, relevant sociocultural idioms of distress, and considerations. We include a discussion on stigma, as one key response to mental and relational health problems in Uganda. Further, we use clinical examples from Uganda to describe salient and common sociocultural idioms of distress that shape how Ugandans experience and express various mental health problems, and subsequent help-seeking behaviors. We end with a discussion by offering implications for sociocultural experiences and considerations to improve mental health service delivery in Uganda.

In Uganda, the subject of mental health has gained increased attention in recent years, with most initiatives focused on attempts to decentralize and integrate mental health into primary health care (Kigozi et al., 2010) as well as, developing culturally relevant interventions to improve mental health services (Sensoy Bahar et al., 2020). Despite some positive reforms in Uganda's mental health landscape, the prevalence of mental health problems is still high (Molodtynski et al., 2017). Given Uganda's immense cultural diversity and inadequate allocation of resources to mental healthcare, understanding salient sociocultural factors and how they may influence people's experiences of symptoms as well as help-seeking behaviors is critical. Although mental health is understood as a universal phenomenon (Nalukenge et al., 2019), the literature on salient socially meaningful and culturally resonant ways of experiencing, expressing, and seeking treatment for mental health symptoms is still limited in Uganda (Backe et al., 2021; Kim et al., 2019; Nsereko et al., 2011). The available literature needs to be synthesized to ease access and digestion for scholars and practitioners. Moreover, most existing literature on socio-cultural considerations of mental health in Uganda offers little to no actual clinical examples to help the reader apply the context of what they are reading.

Given the rationale above, the purpose of this paper is to highlight salient social and cultural considerations in the literature on mental

health in Uganda. We include real case examples to illustrate some ways that social and cultural factors might present in mental healthcare in Uganda. Our goal is not to convey a universal approach to mental health and healthcare in Uganda, but rather to emphasize the value of attending to social and cultural factors relevant to common mental health problems and subsequent help-seeking behaviors in Uganda. Having concrete information on important sociocultural considerations of mental health in a multi-ethnic country such as Uganda is important for several reasons. First, it continues to inform and emphasize to Ugandan practitioners and policy makers on important aspects of culture to prioritise and invest in. In turn this may impact plans for improving access to mental health services and strengthen campaigns to fight negative perceptions and stigma towards mental health at community and national level (Quinn and Knifton, 2014). Globally, an article on sociocultural considerations of mental health in Uganda contributes to the global mental health agenda as it relates to the development, implementation, and sustainability of mental health interventions for historically underrepresented populations in low-income settings, such as those in Uganda (Kola et al., 2021). Specifically, it informs and offers insight to international collaborators and partners (e.g., the Mental Health Gap Action Program; mhGAP) on culturally relevant concepts to consider in developing and/or adaptation of evidence-based mental health treatments for various problems in Uganda (Dua et al.,

* Corresponding author. concerning this article should be addressed to
E-mail address: ronaldas@msu.edu (R. Asimwe).

2011; Keynejad et al., 2018).

We open this article with a discussion on the cultural and contextual background of Uganda which is important for setting the stage. Next, we discuss the relevant context of mental health in including, prevalence rates of mental health disorders, policy issues, services available in the system alongside major challenges still facing the mental health system in Uganda. We believe that a discussion of mental health problems and services necessitates a discussion on common community responses to mental health problems. Thus, we situate stigma as a major community response that shapes perceptions towards mental illness and subsequent help-seeking behaviors for Ugandans. The discussion on stigma is followed by a discussion of major sociocultural idioms of distress and help-seeking behaviors, which includes ideas of religion and symbolic efficacy. Finally, is a discussion on various psychometrically validated assessment instruments that have been developed and/or adapted to assess common mental illnesses and relational problems in Uganda. We end our discussion by offering two clinical case examples, w which we use to describe local expressions of various symptoms of psychological distress as well as culturally resonant ways of help-seeking behaviors. Finally, we offer clinical, research, advocacy, and policy implications for considering common sociocultural factors and idioms of distress related to mental health in Uganda.

1. Cultural and contextual background on Uganda

Uganda is found in East Africa, and borders Kenya to the east, South Sudan to the north, the Democratic Republic of Congo to the west, Tanzania to the south, and Rwanda in the southwest. Uganda is relatively one of the small countries in Africa in terms of geographical area (estimated at 236, 040 square kilometers). However, the country is densely populated. Recent data estimates the population of Uganda to be 48, 582, 334 (a 2.82% increase from 2022), making it number 31 in the list of countries by population (World Bank Population Estimates, 2023). Approximately 55% of Uganda's population are children below the age of 18 years, and about 28% between the age of 18–29 years are subsistence farmers living in rural areas of Uganda (Uganda Bureau of Statistics, 2018). Consequently, Uganda is among the countries with the youngest population in the world (World Bank Population Estimates, 2023). As of January 2023, Uganda's life expectancy was predicted at 64.38 years, marking a 0.51% increase from 2022. The fertility rate of Uganda is currently at 4.4 births per woman (World Bank Population Estimates, 2023). Given the arguably high fertility rates, Uganda's population is estimated to be 89,446,904 million people (1.75 increase) in 2050.

Uganda is one of the most culturally heterogeneous countries in Sub-Saharan Africa. The 1995 Constitution of Uganda recognizes 56 indigenous ethnic groups with each speaking a different language (Tulibaleka et al., 2021). The tribes in Uganda are often grouped into two major ethnic groupings which are the: Bantu, which is the prominent ethnic group in sub-Saharan Africa. The Bantu in Uganda mainly occupy central, western, eastern, and southwest parts of Uganda. The Baganda are the largest tribal group (approximately 20% of the population), followed by the Banyankole/Bahima (15%), the Basoga (10%), and the Bakiga (7%), among many others. The second ethnic grouping are the Sudanic and Nilotic group, whose main inhabitants are in North, Northwest/-East, and some parts of Eastern Uganda. Ethnic groups in this region include the Acholi, Langi, Alur, Karamajong, Iteso, Kakwa, and others. English is Uganda's official language used for instruction in schools, and other agencies and institutions (e.g., the parliament), while Luganda is a language spoken by many in the day-to-day conduct of business and communication. There have been ongoing debates to make Swahili the national language, but these have not been successful, primarily because natives are rather comfortable using English instead of Swahili for national and international engagements. With the recent influence of world powers like China (Nassanga and Makara, 2016), a few schools in major cities of Uganda have started teaching Mandarin, but the language

has not spread in other sectors of the country beyond educational institutions.

Despite the immense ethnic diversity of Uganda, mental health service delivery, policy, and practice are yet to embrace multiculturalism. Most of our practices and mental health training policies are still heavily rooted in western individualistic ways and conceptualizations of mental health and wellness. In the section below, we offer a detailed summary of the context of mental health, including relevant prevalence rates of common mental health disorders, services available, issues related to policy, alongside challenges still facing the mental health system and service delivery in Uganda.¹ Additionally, we discuss (1) relational problems, primarily intimate partner violence (IPV) as a unique, phenomenon that negatively impacts the mental health of many individuals, families, and communities in Uganda, and (2) stigma as a common community response to mental health problems. Our main goal of this section is to provide a wider picture of the state of mental health in Uganda before discussing salient sociocultural factors, idioms of distress, and help-seeking. The Context of Mental Health in Uganda; Prevalence, Policy, Services, and Challenges.

1.1. Prevalence of mental disorders in Uganda

Mental health disorders continue to be a public health challenge in Uganda. A recent systematic review of 24 prevalence studies in Uganda found that 22.9% of Ugandan children below the age of 18 years, and 24.2% of adults were suffering with a mental illness (Opio et al., 2022). Depression and anxiety were the top two most common mental health conditions, with approximately one in four Ugandans being affected by these mental health conditions. Specifically, the prevalence of anxiety among children was reported at 14.4% and at 20.2% in adults. The most common anxiety disorders in Opio and colleague's (2022) review were post-traumatic stress disorder (PTSD), generalized anxiety disorders (GAD), panic disorders, separation anxiety, social phobia, obsessive compulsive disorders and adjustment disorders. Similarly depressive disorders were reported at 22.2% prevalence rate for children and at 21.2% rate in adults. The depressive disorders identified included, major depressive disorders (MDD), dysthymia, and bipolar disorders. Another study has reported the one-year prevalence of psychotic disorders (including schizophrenia spectrum disorders and bipolar affective disorders) to be at 63% (95% CI: 60.2–65.1) among first treatment contact patients at the Butabika national psychiatric referral hospital in Uganda (Mwesiga et al., 2020). The prevalence of psychotic disorders was higher in women (OR 1.58 (CI:1.46–1.72) after adjusting for the patient's residence (Mwesiga et al., 2020).

Other studies have identified posttraumatic stress disorder (PTSD) as a highly prevalent mental health problem affecting Ugandans (Abbo et al., 2009; Abas et al., 2014; Mugisha et al., 2013; Winkler et al., 2015). Particularly, with a significant population of refugees in Uganda, PTSD rates as high as 67% (e.g., Nakivale refugee camp, Bapolisi et al., 2020) with high depression, anxiety, and substance use comorbidities have been reported among Ugandan refugee populations. Further, research has highlighted drugs and substance use disorders to be on the increase

¹ Like in most of philosophical literature, the phrase 'Ugandan culture,' are used interchangeably to indicate generalizable theoretical abstract theme (s) that are dominant and enduring in many Ugandan traditions and experiences of mental health among individuals. This does not imply that experiences are static or that Uganda is monolithic but a recognition of the everchanging nature of cultural traditions. Thus, the prefix 'Ugandan' is this paper should be viewed as a philosophical concept related to a state of being and mind as experienced in diverse communities in Uganda. In other words, "Ugandan" is used here, in a similar manner the prefix "Western" is often used in literature to refer to certain dominant themes in Western cultures and thought. It does not imply that all cultures or even experiences of mental health and help-seeking behaviours in the "West" are the same but rather that some aspects of experiences and behaviours are shared among Western societies.

among youth between the age of 13–18 years and men lower-income settings of Uganda (Abbo et al., 2016; Byaruhanga et al., 2008; Wagnier et al., 2012). The most abused substances include cannabis, alcohol, and cigarettes (e.g., Kaggwa et al., 2022; Miller et al., 2021; Petersen et al., 2017). Other risk factors associated with high prevalence of mental disorders include high HIV and malaria prevalence rates, community history of war and political violence, the increased burden of non-communicable chronic diseases (e.g., cancer and diabetes; Dalal et al., 2011), and poor/under-resourced healthcare systems (Kaggwa et al., 2022). Despite acknowledgement that sociocultural factors are important in understanding how individuals experience and express mental health problems, much of what is known about mental health research in Uganda still heavily relies on individualistic and primarily Western conceptualizations of mental health and expressions of mental health symptoms (Abbo et al., 2009; Kopinak, 2015).

1.2. Relational problems

We use Heyman et al. (2009)'s definition of relational problems to refer to a family of clinical behavioral and psychological patterns which occur between individuals within a family or community setting that negatively impact (e.g., cause distress, pain, loss of freedom, or disability) the relational functioning and mental well-being of an individual, a family, or a community. Research from Uganda has highlighted intimate partner violence (IPV) as an increasing public health concern (Abramsky et al., 2016; Asimwe et al., 2022; Okumu et al., 2022). A significant amount of mental health problems (e.g., depression, anxiety, and post-traumatic stress disorder and others) have been reported among individuals, families, and communities who have experienced IPV (Osinde et al., 2011; Okumu et al., 2022; Valentine et al., 2019).

Traditionally, the literature on IPV in Uganda has predominantly highlighted women as victims of IPV and men as perpetrators. A Uganda Bureau of Statistics (2021) report found that approximately 58.4% of Ugandan women in intimate relationships experienced IPV (including emotional, physical, or sexual) in their lifetime, with 36.6% having experienced IPV within the past year. However, recent research has also highlighted men as victims of IPV. For example, Gubi and Wandera (2022) found that 44% of men experienced some form of violence perpetrated by their female partner, with emotional violence (36%) being the most prevalent, followed by physical IPV and sexual IPV at 20% and 8% respectively. In general, pre-existing sociocultural factors (e.g., hegemonic masculine values) and socioeconomic factors such as low levels of education, low wealth index, and limited decision-making power have been identified as risk factors for experiencing violence among women and children in Uganda. For men, factors associated with being victims of IPV highlighted in literature include, religion, the number of female spouses, the partner's controlling behaviors, witnessing violence from one's family of origin, and substance use (Gubi and Wandera, 2022).

In addition to IPV, child and youth maltreatment has also highlighted as a public health concern with significant effects on the mental health of children below the age of 18 years old in Uganda. For example, one study of 232 school-going children and adolescents found that all participants had experienced at least one type of violence (including physical, emotional, sexual and neglect) in their lifetime (Ainamani et al., 2020). Other studies have found that children and youth who experience violence in their homes or communities were at an increased risk of substance abuse, suicidal ideation (e.g., Culbreth et al., 2021), and other psychological disorders such as PTSD, depression, and anxiety (Olema et al., 2014).

Given the severe negative impacts of violence on the mental and relational health of individuals, families, and communities in Uganda, scholars have called for the development and implementation of multicomponent family and systemic interventions to address violence on multiple levels (e.g., family and communities) in Uganda (Osinde et al., 2011; Valentine et al., 2019). Recommendations for reducing IPV

specifically include developing interventions that address gender norms and increase women's decision-making power in the home, economic vulnerability, and comprehensive screening for multiple forms of violence in larger systems such as schools, communities, and media platforms. Conversely, recommendations for reducing violence against children and youth include the development and widespread implementation of parenting interventions to teach positive parenting skills (e.g., Siu et al., 2017). A failure to establish programs that challenge existing discriminatory policies and practices that maintain social inequities may continue to increase experiences of violence in Ugandan households.

1.3. Mental health policy issues, services, and challenges

Uganda is among the few African countries with an arguably robust mental health policy (Nicholas et al., 2022; Kigozi et al., 2010). This policy was first inaugurated by Uganda's ministry of health in 1996 to try and bridge the gap in healthcare service delivery nationally. Since its inception, the policy has undergone several revisions. Specifically, the policy was developed to; (a) ensure that mental health services were decentralized and integrated in Primary Health Care (PHC) settings, (b) ensure that there is availability and equal access to high quality evidence-based mental health treatment programs, (c) encourage family and community participation in mental healthcare, (d) protect the rights and lives of people living with mental illness and (e) end stigma and negative perceptions and attitudes towards mental illness (Kigozi et al., 2010, 2016).

While the national mental health policy demonstrates some progress, there are major challenges still facing quality mental health service delivery in Uganda. Perhaps the number one challenge is the lack of sufficient resources (human and financial) to provide quality care and services (Kitafuna, 2022). Of Uganda's 9.8% total gross domestic product budget for healthcare, only one percent is allocated to mental healthcare (Kigozi et al., 2010). Moreover, majority of the already limited funding available for mental healthcare goes to treatment of major psychiatric disorders (e.g., psychosis, bipolar disorders, and schizophrenia) for individuals admitted in inpatient care facilities such as at the Butabiika national and regional mental health hospitals (Kigozi et al., 2010). Common mental health conditions such as depression, anxiety, posttraumatic stress disorder (PTSD), and relational problems like intimate partner violence often go untreated in the population. Despite having some trained mental health workers (e.g., social workers, community psychologists, and counselors) throughout the health system, few Ugandan health care professionals receive adequate training in identifying and treating psychiatric disorders as well as relational or family-level problems such as intimate partner violence and violence against children (Rodin et al., 2021). In terms of human resources, majority of the trained mental health professionals in Uganda are concentrated in urban areas (e.g., Kampala, Mbarara, Gulu, and other urban areas) and only a few are posted in government regional mental health referral hospitals. Moreover, a considerable number of professionals in private practice charge expensively for their services, which automatically eliminates lower-income Ugandans from receiving quality mental health care. This has created an imbalance in care and service delivery between urban and rural areas of Uganda, where poverty tends to be a big barrier to access to quality healthcare in general (Molodynski et al., 2017; Nakku et al., 2016). Subsequently, Uganda has no national coverage for community mental health treatment for other types of mental health problems.

Other challenges include a lack of family systems training for mental health professionals interested in family-level intervention work. Most of the training for mental health professionals at the graduate level is still individual based (e.g., clinical psychology, counselling psychology) with little emphasis on systemic or familial conceptualizations and interventions of mental health problems. A lack of family-based treatments has left a huge gap in service delivery at the national level,

particularly for children, youth, and families presenting with problems that require high level systemic training and knowledge of systems level interventions such as cyclical, family skills training. Majority of family-level training and interventions are offered through non-profit organizations (e.g., Save the Children Uganda, Vivo International, World Vision, and others) or academic-community partnerships to implement grant-funded treatment programs. With more Ugandan mental health professionals acquiring advanced training in Couple and family therapy from Western countries (e.g., the first author), we hope that the landscape of mental health practice in Uganda will shift to focus more on systemic conceptualization and treatment of mental health problems.

2. Community responses to mental health problems; a focus on stigma

Stigma is an important concept to consider and situate in a discussion of sociocultural consideration of mental health in Uganda. Despite increased campaigns to counter stigma and negative perceptions towards mental illness and help-seeking in Uganda, stigma is still a common community response in many parts of Uganda (Quinn and Knifton, 2014; Rasmussen et al., 2019). Similar to many cultures across the world, stigma related to mental illness in Uganda manifests and is enacted in various ways, which overall encompass but are not limited to: (1) perceiving mental illness as a sign of laziness or weakness, (2) shaming, labelling, and blaming a person with a mental illness, (3) viewing people with mental illness as deserving a punishment or death, (4) fear of the person with a mental illness as dangerous to themselves and others, and (5) isolating the person with a mental illness from the family or community members (Quinn and Knifton, 2014; Rodin et al., 2021). In their study with 106 mental health stakeholders in Uganda, Nsereko et al. (2011) reported that the negative perceptions of individuals with both mild and several mental illnesses contributed to mental health stigma including, derogatory labels, and fear of individuals and families living with mental health problems (Nsereko et al., 2011). This fear prompted the removal of people living with mental illness from society to protect those in the community from being hurt or threatened by the patients (Johnson et al., 2009; Nsereko et al., 2011).

The perception that mental illness is caused by evil spirits (e.g., witchcraft, failure to respect/honor the cultural gods, and others) is prevalent in discourses of mental health in Uganda (Miller et al., 2021; Nsereko et al., 2011). These traditionally held beliefs often cause family and community members to ridicule and harshly treat people with mental illness (van Duijl et al., 2014; Verginer and Juen, 2019). In extreme cases, individuals with a mental illness may be restrained, stoned, and/or expelled from the community (Quinn and Knifton, 2014). These forms of ill treatment may cause people to hide symptoms from others; this may include not only severe symptoms but also common symptoms of emotional and relational distress. Such stigma and marginalization are exacerbated by poverty and limited financial resources that access mental health care, thereby limiting help-seeking among people living with mental illness. Further, there are reports of self-stigma which can lead individuals with a mental illness to delay, reject, and feel ashamed to seek help for their condition (Ssebunnya et al., 2009). In summary, recognizing how cultural and social factors affect how people perceive and seek care for mental health and illness are both imperative and timely given the significant mental health needs documented among children and adults in Ugandan settings.

Lee et al. (2022) reported a demonstrated reluctance among study participants in rural Uganda to interact with those who were mentally ill, which appeared to be motivated by worries about risky behaviors and the perceived threat to the community that those who were mentally ill were exhibiting. For example, one of the frequent indications of mental illness that community members brought up was violent behavior, such as raping children, destroying property, throwing stones at people, and beating (Lee et al., 2022). Although depression is

one of the most prevalent psychiatric diseases presenting to general practitioners in Uganda, available literature and clinical observations indicate that it is rarely identified as such (Nsereko et al., 2011; Okello and Ekblad., 2006) The clinical presentation of depressive illnesses varies significantly among cultures in addition to having different symptoms depending on subtype and dimension (Okello and Musisi, 2006). These discrepancies may be due to differences in cultural ways of expressing depression, sickness behaviors that have been culturally transmitted, value systems, linguistic symbols, and health service characteristics (Okello and Ekblad., 2006). These differences may significantly differ from schizophrenia or psychosis thereby impacting stigma within Ugandan populations.

Stigma and the negative perceptions towards mental health are not limited to the general population but are also existent among some professionals in Uganda. A recent cross-sectional study of 259 undergraduate medical students attending a public university in Uganda found that although a high percentage (77.72%) of medical students had high knowledge of mental health, they still held negative attitudes and perceptions towards mental illness (Kihumuro et al., 2022). The student's negative attitudes and perceptions were associated with strongly held religious beliefs and prior experience of a mental illness either at a personal or familial level Kihumuro et al. (2022). Research shows that demographic and socioeconomic factors are highly associated with stigma against mental illness and help-seeking. For example, Hawkins et al. (2020) in their study of patients receiving mental health services from a hospital in western Uganda found that stigma was highly associated with socio-economic factors (e.g., poverty, unemployment, and financial stress). Subsequently, these factors negatively impacted the intrapersonal beliefs and patient's engagement in mental health care. Further, other scholars have noted that stigma tends to be less among younger people compared to adults. For example, according to Kuteesa et al. (2012), younger people tend to be open to acknowledge about the importance of mental health and seeking professional help compared to the older generation.

In general, most Ugandans tend to delay engaging with the mental health care providers for several reasons but mostly due to a general lack of knowledge regarding mental illness and psychiatric terms among community members in Uganda. Several studies in Sub-Saharan African countries, including Uganda indicate the only mental illness that requires psychiatric treatment is "madness." Mood-related problems like depression and anxiety tend to be conceptualized as "distressing states caused by challenges of life" and therefore given less medical and psychiatric attention (Ventevogel et al., 2013; Okello and Ekblad, 2006). Second, there is limited awareness of where and how to access treatment, mistrust of the healthcare system because many people encounter stigma associated with mental illness and care-seeking for mental illness (Quinn and Knifton, 2014). Thus, most Ugandans tend to approach mental illness differently using deeply held beliefs, and many tend to seek social or spiritual solutions for their symptoms as opposed to biomedical care (Byaruhanga et al., 2008). This is not surprising in a multi-ethnic country that comprises more than 56 tribes, each with people who practice different cultural traditions and speak different languages.

3. Sociocultural idioms of distress and help-seeking in Uganda

Mental health service providers as well as psychiatric diagnostic manuals have long recognized the significant role of understanding local idioms of or expressions of distress particularly among the culturally diverse populations and how these can be integrated in mental health research and practice (Cork et al., 2019). As part of a groups or person's sociocultural milieu, local idioms of distress play a role in community experiences of mental illness and subsequent help-seeking responses in Uganda (Hays and Costello, 2022; Hjelmeland et al., 2008; Verginer and Juen, 2019). Thus, an in-depth exploration of important idioms of distress in Uganda can further the development of culturally and

contextually relevant prevention and intervention (Abbo, 2011; Mendenhall et al., 2014). Most cultures provide supernatural descriptions of mental health conditions that are commonly endorsed by community leaders such as cultural advisors (Abbo, 2011; van Duijl et al., 2014; Verginer and Juen, 2019). Although there is a contemporary African population exposed to global trends and modern education that references ancestral spirits as one of the contributions to mental illness among many other factors (Van Duijl et al., 2014; Verginer and Juen, 2019), other notable causes of mental illness could be genetic, spiritual, psychological, or social factors (Abbo et al., 2013; Verginer and Juen, 2019).

In most of sub-Saharan Africa where Uganda is located, many people employ idioms of distress to communicate suffering and shared ethno-psychologies (Backe et al., 2021). These idioms of distress contain locally and culturally shared interpretation, significance, and relevance of social, psychological, and somatic symptoms. Table 1 includes a list of some of the common idioms of distress in Uganda and in Kenya, a Swahili-speaking country and Uganda's neighbor. As examples, these idioms are significantly passed on from generation to generation (Okello and Musisi, 2006). Ardently, the authors utilized idioms from Kenya in this article due to the shared similarities with and Uganda compared to other Sub-Saharan countries. Backe et al. (2021) discuss a detail of idioms of distress in Sub-Saharan countries and the Kenyan and Ugandan ones seem more closely shared. Moreover, some of the tribes in Uganda especially at the borders of Malaba and Busia utilize Swahili and have close customs and cultural practices with neighboring Kenyan communities. For example, in In Kenya, a Swahili-speaking country and Uganda's neighbor, an analysis of 100 life history narrative interviews among patients seeking care in a public hospital found that the Kiswahili idioms of *dhiki* (translated as "stress or agony"), and *huzuni* ("sadness or grief"), and *kufikiria sana* ("thinking too much") were commonly acknowledged as powerful idioms of distress associated with various symptoms of psychological distress (Mendenhall et al., 2019). *Huzuni* was associated with depression that occurred when an individual deeply internalized sorrow after the death of a loved one. Conversely, *Dhiki* was not well-defined, but most participants in the study agreed that the idiom resonated with stress, and in general was resonant to individual suffering from the "social and internal, emotional world" (Mendenhall et al., 2019, p.629). *Kufikiria sana* was generally used to convey intense thinking about distressing personal, familial, and professional experiences (e.g., financial worries, death/loss of a loved one, feeling unsafe in one's neighborhood, past traumatic experiences etc) that caused an individual to be consumed in "too much thinking (Backe et al., 2021)."

Relatedly, depression is described as "sadness" or "madness" in Uganda which delineates from the typical DSM V diagnostic clinical criteria (Hay & Costello, 2022). Among the Baganda in central and southern Uganda, depression is commonly conceptualized as "eByekika" translated in English as "Clan illness/problems" (Okello and Musisi, 2006). This "Clan illness" often manifests with mood congruent delusions and is believed to be caused by "actions or behaviors of the living towards the dead" (p. 1) such as neglecting or abandoning the traditional rituals (e.g., the worship of ancestors/lubaale), breaking taboos (e.g., killing someone, building in a forbidden place, and eating foods

unacceptable to the gods), and finally, mixing of African with Western belief systems. Many Baganda believe that the dead, although not physically living are alive in the form of spirit and can make or take away life. Thus, people get depressive symptoms (*eByekika*) when the clan spirits make demands.

Several other local idioms of distress exist among other Ugandan tribes. For example, the Acholi people of Northern Uganda describe psychological problems e.g., "depression-like" symptoms (as 'two tam, par and kumu'), anxiety-like (*ma lwor*) and conduct problems (*kwo maraco*), that resemble Western descriptions of mood, anxiety, and conduct disorders (Betancourt et al., 2009). However, culture-specific elements emerge in the way participants described these psychological problems; for example, although 'kumu' had features similar to those of mood and anxiety disorders, one community member described it as "a problem of experiencing extreme and persistent grief or sadness" (see Betancourt et al. 2009, p.6) with key characteristics of sitting with one's cheek in the palm and sitting alone or in isolation. Similarly, *Ma Lwor* (anxiety-like problems of children) shared DSM-V symptoms of Generalized Anxiety Disorders e.g., sleep disturbance, increased arousal, and restlessness but culture-specific symptoms of *Ma Lwor* included "not liking noise and running around" (Betancourt et al., 2009).

Similarly, a qualitative exploration of maternal mental health and help-seeking behaviors in Teso sub-region of Uganda found that *adeka na aomisio* (or 'sickness of thought') was a common idiom of distress used to convey several social and psychological adversities (e.g., intimate partner violence, unsupportive spouses, financial stress, and physical illnesses) experienced by pregnant and postpartum women in this region (Tol et al., 2018). A surprising finding was that several women in the sample referred to thoughts as tangible forces that could be eliminated from one's head/mind as expressed in phrases such as "reducing thinking in the mind," and "making your heart settled" used by women (Tol et al., 2018). There were notable differences in the symptoms listed to represent sickness of thought by primary healthcare workers and mental health specialists compared to symptoms listed by perinatal women and community health workers. For example, while primary healthcare workers and mental health practitioners listed emotional symptoms such as excessive sadness, low mood, feelings of worthlessness, excessive worrying, and suicidal thoughts, perinatal women and community health workers listed behavior-like symptoms including less sleep, crying, not eating, and feeling weak. Nonetheless, the diverse participants in this sample (i.e., traditional and faith healers, community health workers, primary healthcare workers, and mental health specialists), shared a common belief that indeed, sickness of thought significantly impacted the mothers in this community.

4. Religion and symbolic efficacy

The concept of symbolic efficacy posits the centrality of religion and spirituality in the lives of many Ugandans (Whapham, 2021). Thus, discussing religion and its influence is critical in enriching the understanding of sociocultural considerations of mental health in Uganda. Most Ugandans generally believe in the spiritual world; one that is beyond what they can see (Mugisha et al., 2013; Okello and Musisi, 2006). Religion and spirituality are often used interchangeably; they characterize a belief in, and a connection to a Supreme Being (s) who is/are sacred, invisible, and transcendental (Mugisha et al., 2013).

Prior to the introduction of Western religion on the African continent, sorcerers, diviners, and soothsayers were central mediators between God and people in the traditional African religion. The three served as interpreters of god's wishes to the people and helped to streamline behavior in society (Idang, 2015). Although there are diverse religious practices and deities in Africa, Mbiti (1970) contends that, "God takes the highest possible position" over all others forms of deities. To the African, God is acknowledged as the supreme creator of the universe; He is omniscient (all knowing), Omnipresent (everywhere) and accessible to every human, Omnipotent (all-powerful),

Table 1
Examples of idioms of distress and their meanings.

Idiom	Meaning	Origin
Dhiki	stress or agony	Kenya
huzuni	sadness or grief	Kenya
kufikiria sana	thinking too much	Kenya
eByekika	clan issues/problems	Uganda
lubaale	ancestral gods	Uganda
two tam, par and kumu	depression-like" symptoms	Uganda
ma lwor	"anxiety-like" symptoms	Uganda
kwo maraco	conduct problems	Uganda
adeka na aomisio	sickness of thought	Uganda

transcendental, and immanent (Mbiti, 1970). Further, God is acknowledged as the “consoler, helper, and comforter of those in pain for various reasons including mental health problems” (Mugisha et al., 2013, p. 349). In contemporary Africa, it is not uncommon to find many who integrate both the African traditional religious practices in addition to Christianity and/or Islam.

In addition, religion and spirituality are key sociocultural backbones of the way mental illness and relational distress is experienced, expressed, and treated in Uganda. In view of symbolic efficacy, to understand the experience of mental illness as praxis, it is necessary to consider it as a dynamic process that, depending on the severity and type of mental illness, may involve several actors and a variety of therapeutic techniques (Whapham, 2021). Through a process of negotiation, the different actors construct the meaning of the illness as well as its subjective experience (Whapham, 2021). For example, most religious people in Uganda believe that Satan and evil spirits are real entities (Verginer and Juen, 2019). Thus, sinful habits and desires caused by Satan are believed to be major causes of demonic attack. An individual believed to be possessed by Satan or evil forces ought to seek forgiveness from God, and if they do not, the attack by evil spirits can be severe and lead to physical and psychological suffering. Other Christians perceive problems such as suicidal behavior to be “spiritual conditions” caused by evil spirits (e.g., Mugisha et al., 2011, 2013). Some even believe that a person who experiences suicidal thoughts, attempts, or commits suicide deserves to be punished by God and the Church.

Although spirituality and faith are important to mental health and help-seeking in Uganda, they are often invisible and informal components of mental health systems, processes, and policies (Mugisha et al., 2013). There are several factors contributing to this dichotomy but the most noticeable is the long-held tension between religion and science (Osafo, 2016). Prior to the introduction of Western science and religion in African countries, religion hosted science in many African countries. This was because many Africans held mixed views (i.e., both natural and spiritual) about the etiology of illnesses, including mental illnesses. However, the introduction of colonial structures (e.g., the missionary churches) across African countries alienated many Africans from their traditional ways of healing in favor of Western science and religion. As a result, this has had tremendous impacts on the help-seeking behaviors of Ugandans. To date, religious leaders (commonly known as ‘men of God’) are sought after by some Ugandans (religious and non-religious) as the first line of treatment for common mental health and relational problems (Knizek et al., 2013). Treatment approaches used by religious and spiritual healers commonly include the reading of Holy Scriptures (*okusoma ebyawandikibwa* in Luganda). In these practices, clients are encouraged by their religious leaders to read and memorize verses in the Word of God (i.e., the Bible) and recite them to combat a particular mental illness and any other relational problems (Verginer and Juen, 2019). Other commonly used religious interventions include intercessory prayers for the mentally ill and their family, praying the rosary, and repentance for cleansing of sins.

In conclusion, traditional and religious beliefs form a core fabric of how psychological and relational distress is experienced and expressed in Uganda. As noted, psychiatric conditions such as bipolar, schizophrenia, and dissociative disorders are often perceived as an outcome of broken associations with ancestors and witchcraft (Abbo, 2011; van Duijl et al., 2014) and in other cases as sin against a Holy God (Verginer and Juen, 2019). In many Ugandan communities, people seek traditional healers (e.g., medicine men, diviners, and faith/spiritual healers) for several ailments and most of the time these symptoms align with mental illness (Abbo, 2011). In some instances, traditional healers are more trusted than medical or psychiatric professionals because they are believed to provide culturally relevant and resonant explanations of mental illness and often are available to offer a strong support system for patients with psychiatric conditions (Abbo, 2011). The cases that people often seek help from traditional healers are often related to land wrangles, grief, non-response to a life call of traditional healing, careless

attendance of traditional ritualism, abandoning relatives and family inheritance (van Duijl et al. 2014). Though patients might adhere to the referred treatment regimen say from medical doctors, conflicts often exist between patients and their relatives over the right approach to treatment. Some patients initially seek medical doctors thinking they may be having commonly diagnosed illnesses such as HIV or malaria. However, their Christian and Islamic beliefs tend to counter their intentions to seek help from traditional healers, and thus return to seek help of faith/spiritual healers (van Duijl et al. (2014)).

5. Assessing common mental health problems in Uganda

A variety of assessment instruments have been documented in the empirical literature to examine mental health and relational health problems in Uganda. To assess common mental health problems, researchers have used, tested, and psychometrically validated both original and adapted versions of various instruments that examine mental health systems based on criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM; Opio et al., 2022). Kaggwa and colleagues’ (2022) recent systematic review of the Patient Health Questionnaire (PHQ-9), a tool widely used to assess depression symptoms, revealed that the PHQ-9 demonstrated psychometric reliability and validity across regional and community settings in the country. The Beck Depression Inventory has also demonstrated evidence for psychometric use to assess depressive symptomatology in various Ugandan communities (e.g., Ovuga et al., 2005; Tusiime, 2015).

Considering complex manifestations of mental health symptoms such as depression comorbid (with HIV, anxiety, substance abuse), some studies engage multidimensional mental health measures to assess complex health needs. For example, Katumba and colleagues (2021) study with people living with depression and HIV/AIDS employed the Oxford CAPabilities Questionnaire for Mental Health (OxCAP-MH) to assess a broad scope of quality-of-life indicators (e.g., social networks, neighborhood safety, discrimination, love and support, freedom of expression, planning one’s life) using the 16-item questionnaire. In the study of traumatic stress, particularly in Uganda’s northern region that was affected by civil war, the Impact of Event Scale-Revised (IES-R) have been used to assess for traumatic experiences and general reactions to traumatic stress (McMullen et al., 2012).

Concerning common relational problems, intimate partner and family violence are commonly studied phenomena in Uganda. Intimate partner violence (IPV) has been assessed using a variety of instruments, including the Conflicts Tactics Scale, the Intimate Partner Violence Assessment Questionnaire by the American Congress of Obstetricians and Gynaecologists (Kinyanda et al., 2016), and the 10-item World Health Organization (2014) instrument to assess emotional, physical, and sexual abuse over one’s lifetime. The Multidimensional Scale of Perceived Social Support (MSPSS), a 12-item assessment of perceived support received from family, friends, and significant others (Zimet et al., 1988) has also demonstrated adequate internal consistency and been validated for use in Uganda. At a broader level, Young et al. (2018) assessed household asset and wealth data to assess the availability of energy, durable goods, and quality of housing in households.

Youth mental health challenges have also been examined using self-assessment tools such as the Youth Risk Behavior Survey (Eaton et al., 2012) to assess general concerns related to youth mental health. Scholars have used items within to assess for specific concerns related to anxiety, depression, and substance use (e.g., Perry et al., 2022). The 2014 Kampala Youth Survey was also developed to assess mental health, violence victimization, and high-risk behaviors such as violence perpetration, alcohol use, and sexual behaviors among youth (Swahn et al. 2014). Table 2 below provides examples of assessment instruments that have been psychometrically tested and validated for use in various Ugandan communities. We emphasize the non-exhaustive nature of this list and include the table below to highlight examples of increasing sociocultural attunement related to mental health assessments used in

Table 2
Examples of assessments for common mental health problems in Uganda.

Assessment	Assessment Area (s)	Citation(s)
1. Patient Health Questionnaire (PHQ-9)	Depression	Kaggwa et al. (2022)
2. Beck Depression Inventory	Depression	Ovuga et al. (2005); Tusiime (2015)
3. Acholi Psychosocial Assessment Instrument	Depression	Betancourt et al. (2009)
4. Oxford CAPabilities Questionnaire for Mental Health (OxCAP-MH)	Quality of life indicators	Katumba et al. (2021)
5. Impact of Event Scale-Revised (IES-R)	Traumatic stress	McMullen et al. (2012)
6. Conflict Tactics Scale	Intimate partner violence	
7. Intimate Partner Violence Assessment Questionnaire	Intimate partner violence	Kinyanda et al., 2016
9. Youth Risk Behavior Survey	General mental health	Eaton et al. (2012)
10. Kampala Youth Survey	High-risk behaviors	Swahn et al. (2014)

Uganda.

Youth and adults in Uganda have also participated in qualitative interviews to assess their experiences engaging in mental and relational health interventions (e.g., parenting intervention; Wieling et al., 2015). Culturally and empirically validated assessments and sociocultural idioms of distress provide a framework to consider important sociocultural factors relevant to mental health experiences in Ugandan communities. In the next section, we present two case examples to highlight social and cultural considerations when conceptualizing mental health and help-seeking in Uganda.

6. Case examples and discussion

The following excerpts were drawn from lived experiences (names are aliases) and briefly illustrate traditional, cultural, religious beliefs and values and their influence on mental health and help-seeking behaviors in Uganda. We also highlight contextual factors and sociocultural concepts relevant to each case and end by discussing opportunities to advance sociocultural and contextually relevant mental health practices in Uganda.

6.1. Case 1

Mark (alias), a 36-year-old man was born in a small village located 100 miles north of Kampala city. Mark lost his parents at the age of four years old in a fatal car accident at the Bujagali river bridge while they were travelling to a party. Their bodies were never recovered because they were washed away by the river. They buried empty coffins without their bodies. Since the loss of their parents, Mark and his elder brother, Marvin experienced severe signs of ambiguous loss (a relational disorder caused by a lack of clarity or facts surrounding the loss of a loved one), including, confusion, despair, hopelessness, lack of sleep, anxiety, and depression. They were taken to their grandparent's home in Masaka, a district in central Uganda so they can find a comfortable place to grieve their parents' loss. The grandparents were very caring and took great care of them. Mark and Marvin's parents were church goers and never wanted their children raised in their grandparents' homes because they believed that their parents still worshipped the traditional gods. Upon their death, Mark started suffering from relentless headaches. His grandparents initially attempted treating the headache with Western pain medicine, but Mark's symptoms did not improve. Mark's grandparents decided to take him to a traditional healer, claiming someone in the community that did not want Mark to have a successful education was bewitching him. Mark and Marvin grew up observing their grandparents' rituals and customs and although they tried to introduce them

to these customs, they never fully adopted them. At the age of 7, Mark was taken to school by his father's sister, who believed that the children needed to have a formal education. He studied until his senior three (sophomore year), but he was discontinued. At school, Mark's grades were very poor; he failed to understand the basic concepts taught and had a short attention span. He was also always absent minded. He then was taken to a technical institute, where he enrolled for plumbing, but he was still discontinued because of being aggressive with a teacher. He then started living with his brother's family, where he used to sometime take care of the children, but he still showed signs of absent-mindedness to details. It became apparent to his brother that Mark was not functioning and so he tried to seek some kind of help for him. He tried to take him to church, and they told him to pray for his brother to evoke the faith that can "heal" him. However, it did not seem to work. He then got advice from his wife who told him that maybe Mark needed a therapist. Marvin found a therapist that could treat his brother. Mark started seeing a therapist and the first day he walked into the office, he had forgotten the directions to the place until he called his brother for the address. His brother drove from his work and picked him up and took him to the shrink. On meeting the therapist, Mark was convinced that his relatives did not want him to succeed and study because he would be better than their children and so they "bewitched" his brain. He believed this made it difficult for him to concentrate on anything.

6.2. Case 2

Blessing (hypothetical name), a 27-year-old woman lives with her father and three siblings in the suburbs of Kampala city. She lost both her mother and her 38-year-old brother to cardiac arrest. Her brother took care of the home finances before he passed. Blessing is a teacher in a secondary school and sells secondhand clothes to make additional income. The money she makes helps her take care of financial responsibilities at home. Blessing inherited hypertonic cardiomyopathy (a disease of the heart muscle where the muscle wall of the heart becomes thickened) from her mother, just like her brother Benjamin. Left untreated, the condition can lead to heart failure. Since the diagnosis, Blessing has never found it easy to speak openly about her condition. She has experienced extreme anxiety, depression, and hopelessness that her condition will never heal. However, when her mother and brother died, she found courage to speak about her health. Her treatment was delayed because three family members including her suffered from the same disease and needed treatment which was costly. The lack of enough funds slowed down Blessing's treatment leading to heart failure. She worried that she was not going to live longer and associated her condition to "mizimu gye kika" (translated as "generational curses") because the same condition had killed her grandmother, mother, and brother. She feared for her life and knew any time this curse would take her to the grave. In desperation, Blessing sought medical advice. The doctors suggested putting her on different drugs or doing a heart transplant. Blessing thought all these measures were not going to work because she thought her condition had a spiritual and generational root. She believed if left untreated spiritually (i.e., break the generational curse), it would kill her and follow her children, grandchildren, and future generations. Because of being in and out of the hospital for doctors' appointments, Blessing lost her jobs. Furthermore, her perception of heart disease influenced her experience of dreams related to her grandmother visiting her and talking about heart disease. She often saw her mother and brother calling her out and this gave her a strong reason to think the problem was spiritual. At some point blessing thought that her family had this disease because their grandmother might have wronged God, and this made her feel betrayed by her grandmother. Blessing was sure if she could only repent for her grandmother's sin, God would heal her immediately, and free her and the next generation from the heart disease.

6.3. A summary of the cases

Conceptualizing and understanding psychological distress in Uganda involves sociocultural and contextual awareness. Both Mark and Blessing's stories reveal cultural nuances in their experience and meaning making around psychological distress. In Mark's case, moving from 100 miles north of Kampala city to Masaka, a district in central Uganda, presents critical contextual challenges as their move placed them further away from mental health resources largely available in the city. Most professional services including mental health services in Uganda are in main cities with Kampala, the capital city having most of the services. For Mark to move from Kampala to Masaka (about 132 km (about 82.02 mi) from Kampala) meant that he would have limited opportunities to have quality care. In terms of sociocultural factors, being raised by their grandparents following their parents' death led to them receiving help from a traditional healer, and Mark internalizing the belief that his success was hindered due to bewitchment by a family member. This case presents significant family implications, from the initial loss of both parents and caregiving shift to Mark and Marvin's grandparents, to meaning-making and help-seeking around Marvin's symptoms. Further, although Mark's grandparents were extremely religious, they still chose to take Mark to a traditional healer after attempting Western pain medicine that was not effective. The grandparents "claiming that someone in the community was bewitching Mark" further demonstrates the underlying influence of traditional religious beliefs on their assessment of and reaction to their grandson's symptoms.

For Blessing, spirituality informed her belief that her health was primarily generational and rooted in a generational curse or "*mizimu gye kika*," in Luganda. This shaped how she felt about both her family and her health. For example, Blessing's feelings of betrayal from her grandmother stemmed from her belief that that grandmother had wronged God, and thus she was insistent that her mental health could improve through prayer. Blessing believed that her heart disease and the loss of her loved ones which contributed to her distress lack treatment provided by medical professionals. People with such deep convictions may not benefit from biomedical explanations of disease. The strong attachment to generational curses is a sociocultural obstacle to assessment and both short- and long-term treatment. Practitioners need to engage with these nuances in conceptualizing patient mental health problems.

7. Moving forward; take aways from our analysis of sociocultural idioms of distress

Sociocultural factors are critical to mental healthcare and responses to community mental health needs. Uganda has substantial diversity by community, ethnicity, religion, histories, healing practices, and other important social factors. It is not possible to describe all social, cultural, and contextual issues salient to every mental and relational health concern relevant to the nation's 56 tribal communities in one manuscript. In what follows, we summarize a few strategies to advance sociocultural relevant mental healthcare in Uganda. Some suggestions are specific to Uganda, though others can be adapted to other sub-Saharan countries and globally with similar considerations.

8. Clinical perspectives

Integrating information about local concepts of psychopathology (e.g., idioms of distress) into therapy enhances the cultural responsiveness of therapy for individuals and families. This recommendation is supported by the expanding global mental health field, which promotes not only considering factors underlying presenting mental health problems but also understanding factors that promote resilience, adaptability, and wellbeing in communities (Patel et al., 2018). Cultural and community strengths are also critical to mental health practice and clinicians working with Ugandan individuals, children, couples, and families

should integrate strengths based than deficit-based treatments into clinical practice. These may involve discussing local idioms of distress and their meanings with people in treatment. For example, it would be beneficial in the case of Blessing to broadly express the manifestations of generational curses and how social, psychological, and physical health is impacted. Moreover, providing space and opportunities for the descriptions of the acceptable treatments within the community can be considered.

To this end, thoughtfully integrating culturally meaningful concepts and experiences into therapy can enhance the cultural fit of mental health interventions in varying contexts. This may subsequently shift treatment-seeking and enhance communities' access to and acceptance of interventions for common mental health problems in Ugandan communities and ultimately reduce the burden of illness in high-need contexts. Regarding stigma, professionals (including medical doctors, psychiatrists, and others) and religious leaders in positions to help people with mental health problems should first do their self-reflection and correct any existing negative stereotypes around mental illness. If medical conditions (e.g., HIV/AIDs, malaria, cancer, and others) can receive treatment without stereotyping the patient as either "bewitched" or "sinful" mental health problems should be approached in a similar manner by individuals in the helping professions including, religious leaders.

9. Research perspectives

Cultural adaptation frameworks offer important guidance for improving the cultural fit of psychological and behavioral health interventions; that is, frameworks and strategies to enhance sociocultural alignment of programs and interventions in Uganda. Scholars continue to propose key considerations to culturally adapt evidence-based interventions in local contexts (e.g., Mental Health First Aid (MHFA; Hays and Costello, 2022)), while studies of existing culturally adapted interventions (e.g., Interpersonal Therapy adapted by Verdelli et al., 2003; Enhancing Family Connection parenting intervention by Wieling et al., 2017) offer important guidance that can inform adaptation procedures of future mental and behavioral health interventions. Although standardized international diagnostic systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) have been previously used to assess certain MH symptoms in Uganda, some scholars contend that such instruments when used in social and cultural contexts that are not similar to those in HICs, can generate reliable findings (Twesigye, 2014; Fabrega, 1996). Existing cultural and linguistic adaptation of measures (e.g., Kasujja et al., 2022, Katumba et al., 2021) can inform future studies of mental health problems in Uganda and enhance the sociocultural alignment of interventions delivered in context.

Further, research on local idioms of distress in mental health practice is still underdeveloped in Uganda. To date, little is known regarding the integration of idioms of distress in training of mental health professionals, the cultural adaption/implementation of evidence-based family and mental health interventions, and/or in clinical practice. Thus, there is need for research to understand the different ways in which local idioms of distress fit global (biomedical) concepts and similarly research on how global contexts can be localized to understand people's thoughts, feelings, and emotions in Ugandan cultures (Backe et al., 2021). Research of this kind would help mental health professionals provide culturally informed recommendations and care to the individuals they treat (Backe et al., 2021, p. 19)." For example, in the case of Mark, the 'relentless headaches' that are commonly explained by witchcraft, could further be explored, and define the convergence of the biomedical and sociocultural explanations. Research in these areas would only strengthen and increase accessibility to service delivery for the Ugandan population.

While there are glimpses of research on local idioms of distress in Uganda (see Mugisha et al., 2019; Okello and Musisi, 2006; Tol et al.,

2018), there is a need to expand this research and examine local idioms of resilience (Kim et al., 2019). Idioms of resilience explore culturally significant factors that facilitate positive outcomes amidst a range of mental health and relational health problems. This research can also consider how cultural and community strengths influence studies and outcomes of mental and relational health in Uganda. Specifically, this research should employ socio-ecological and processual frameworks to explore both individual level factors and larger societal contexts that foster resilience in Ugandan communities. Such research helps us to understand the factors that facilitate resilience and the complex cultural and socio-political dynamics that perpetuate disparities among individuals' responses to psychological adversity (Kim et al., 2019).

A final implication relates to stigma. While scholars (e.g., Quinn and Knifton, 2014) contend that stigma and negative beliefs about mental health illness vary across cultures, it was beyond the scope of this article to explore all the possible variations, associations, and types of stigmas related to mental illness and subsequent help-seeking behaviors in Uganda. Future research should explore this topic. Specifically, this research should further explore the strength of the relationship between stigma, traditional and religious beliefs, and whether this relationship can be mediated by factors such as an individual's, level of education, professional background, socioeconomic status, availability of community-level social support services and other salient factors. Further, research should also explore individual and family level factors that could serve to prevent and end stigma against mental illness and help-seeking.

10. Advocacy and policy perspectives

In consideration of common sociocultural factors related to mental health in Uganda, policy makers need to invest in deeper understanding of the influence of spiritual and faith-based mental health care in Uganda. Studies continue to reveal that when Ugandans face mental health challenges, they are more likely to seek complementary and alternative health providers such as religious leaders and traditional healers as their first line of support (Mugisha et al., 2013; Mwaka et al., 2015; Verginer and Juen., 2019). This type of care is perceived to reflect people's culture across the Africa continent (Ojagbemi and Gureje, 2020). The clinical examples of Mark and Blessing from Uganda shared above further attest to this fact. Previously, studies from across Africa examined the effect of religion on various mental health symptoms in African settings. For example, a national longitudinal study of adult South Africans found that individuals who were involved in religious activities were at less risk of experiencing depressive symptoms (OR = .85, 95% CI 0.76–0.96) compared to individuals who indicated religion as a less important aspect of their lives (Tomita and Ramlall, 2018). Similarly, another study in South Sudan found that faith and spirituality were protective factors against harmful drug and alcohol consumption among a group of humanitarian workers (Strohmeier et al., 2018). These few select examples across Africa continue to punctuate the significance of religion and spirituality to the mental health of Africans. Thus, neglecting this important group (i.e., religious & traditional healers) of the informal mental health system limits the efficacy of care, especially given increasing mental health needs of the population. Focusing on how to formally recognize and integrate them into the mainstream mental health system would increase service provision especially given the inadequate resources (e.g., funding, and limited mental health hospitals) in the country.

On the other hand, policy makers can implement regulations to maximize protection and minimize the risks of harm to vulnerable populations (e.g., women, children, and people living with HIV/AIDS) seeking mental health care. This includes enacting policies to reduce and possibly end stigma against people with mental illness. We agree with Quinn and Knifton (2014)'s recommendation that stigma against mental illness should be viewed through the lens of human rights and social justice. Considering this recommendation, every individual in Uganda

should be entitled to access to quality and nondiscriminatory mental health care whenever they need it. Rather than stigmatizing people with mental illness, family and community members should be held responsible for ensuring that individuals within their families and communities suffering with a mental health condition should be helped to get the help they need. Additionally, policy can advance the integration of spiritual and faith-based providers by increasing funding support for access to empirically informed trainings and regulating standards of practice based not only in empirical and practice-based evidence but also in traditional and community-based knowledge and wisdoms (Ojagbemi and Gureje, 2020). Together, trainings of new and experienced mental health professionals should incorporate local idioms of distress and socio-cultural concepts of health and psychopathology. Shifting toward cultural contextualization as the standard of training and practice in Ugandan higher institutions (e.g., Makerere University) and community mental health programs enables stakeholders to address critical population-level mental health needs, while considering sociocultural factors relevant to one or more of Uganda's 56 unique tribal groups. Local partnerships and campaigns that are supported by government and policy-relevant entities are also important to the advancement of global mental health. In doing so, engaging institutional and systems-level influences on funding and policy may not only enhance mental healthcare responses, but also have potential to support culturally responsive approaches that can align sociocultural concepts with interventions supported by key funders and policymakers. Hays and Costello (2022) recognized the contribution of 'cultural advisors' as central to the success of Mental Health First Aid curriculum in Ugandan communities.

In conclusion, this paper builds on the limited but growing body of literature documenting sociocultural considerations of mental healthcare in Uganda (e.g., Mendenhall et al., 2014; Ojagbemi and Gureje, 2021). First social and culture influences in conceptualizing mental health problems and illness are clearly explained. Clinicians can utilize this information in their comprehensive work with clients in Uganda and other countries with considerably similar demographics. This paper presents the common mental health problems, local idioms of distress, and other salient sociocultural considerations within the Ugandan population. Frameworks for assessing mental health problems have been shown and case examples demonstrating the impediments to help seeking are articulated. This knowledge can inform policy advocacy by promoting sociocultural considerations for improving mental healthcare at the policy level (e.g., advocating for increased funding support to collaborate with traditional healers), which can strengthen Uganda's existing national mental health policy and ultimately improve communities' access to quality, accessible, and culturally attuned mental health care.

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Ronald Asiimwe: Conception of the article, Drafting the outline and drafting the manuscript, Approval of the version of the manuscript to be published. **Racheal D. Nuwagaba-K:** Conception of the article, Drafting the outline and drafting the manuscript, Approval of the version of the manuscript to be published. **Lekie Dwanyen:** Conception of the article, Drafting the outline and drafting the manuscript, Approval of the version of the manuscript to be published. **Rosco Kasujja:** Approval of the version of the manuscript to be published.

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